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AGAM-P (M) (12 Mar 69) FOR (OT-UT-69B009)

18 March 1969

SUBJECT: Senior Officer Debriefing Report: ~~Spurgeon Neel~~, Period
1 August 1968 - 1 February 1969 (U)-8

Headquarters, 44th Medical Brigade

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10 Spurgeon Neel

1. Reference: AR 1-26, subject, Senior Officer Debriefing Program (U),
dated 4 November 1966.

2. Transmitted herewith is the report of BG Spurgeon Neel, Commanding
General of the 44th Medical Brigade and concurrently Surgeon of Headquarters,
USARV.

11 Feb 69

12 Feb

3. This report is provided to insure appropriate benefits are realized
from the experiences of the author. The report should be reviewed in
accordance with paragraphs 3 and 5, AR 1-26; however, it should not be
interpreted as the official view of the Department of the Army, or of
any agency of the Department of the Army.

BY ORDER OF THE SECRETARY OF THE ARMY:

Kenneth G. Wickham

KENNETH G. WICKHAM
Major General, USA
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DEPARTMENT OF THE ARMY
HEADQUARTERS, 44TH MEDICAL BRIGADE
APO San Francisco 96384

AVBJ CG

1 February 1969

SUBJECT: Senior Officer Debriefing Report

Commanding General
United States Army, Vietnam
APO 96375

1. Reference letter, HQ USARV, File AVHAG-PO, subject as above, dated 10 September 1968.
2. Inclosed are five copies of the debriefing report submitted in accordance with para 1 of the above reference.
3. These past six months may be categorized as a "period of refinement" in USARV medical organization and practices. Hospital units were relocated to maximize capability and to accommodate major troop redeployments as well as the arrival of reserve hospital units from CONUS. Emphasis has been placed upon improvement of administrative practices within hospitals and other medical treatment units to bring them to a level commensurate with the professional practices. These and other aspects of the improvement in management of USARV medical resources are detailed in the inclosed report.
4. I subscribe without exception to the conclusions documented by my predecessor in his report dated 1 August 1968.

1 Incl
as

Spurgeon Neel
SPURGEON NEEL
Brigadier General, MC
Commanding

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DEBRIEFING REPORT

(RCS-CSFCR-7L)

COUNTRY: Republic of Vietnam

DEBRIEF REPORT BY: BG Spurgeon Keel, MC

DUTY ASSIGNMENT: CC, 44th Medical Brigade/
Surgeon, US Army, Vietnam

INCLUSIVE DATES: 1 August 1968 - 1 February 1969

DATE OF REPORT: 1 February 1969

INCLOSURE

(2)

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ANNEX A

INTRODUCTION

1. (U) GENERAL MILITARY SITUATION -- The United States Army in Vietnam has continued to support the Republic of Vietnam Forces in pacification and revolutionary development. United States units continue to accomplish their missions by the deployment of tailored tactical elements into suspected hostile areas to conduct spoiling attacks and reconnaissance-in-force operations. Upon completion of their missions they move to other areas to perform other missions or return to base camp for resupply, refitting and recuperation. Enemy activity has consisted primarily of terrorist and/or harassment attacks. This activity has resulted in the modification of force structures and the redeployment of combat and combat support units. The threat to the Saigon area caused COMUSMACV, in November 1968, to move the 1st Cavalry Division (Air Mobile) from I CTZ to III CTZ.

2. (U) GENERAL MEDICAL SITUATION -- a. The troop redeployments have not significantly altered the hospital work loads of the 44th Medical Brigade.

b. The in-country arrival of reserve component units essentially marked the completion of the Program 6 build-up in medical forces in RVN. An immediate objective was to assure that these new units were effectively utilized as soon after arrival as possible. This was no problem for the smaller units. They had a specific support mission and their construction needs were generally minimal. These units were operational in a few days. With hospital units, however, the problem was more complex. Despite the priorities enjoyed in construction, this factor could have precluded an early operational date for two of the three reserve hospital units. However, by using the reserve hospitals to take over the physical facilities of hospital units already in-country, the reserve units became operational quickly and allowed the 44th Medical Brigade to relocate the supplanted hospitals to provide better balanced support.

c. The 2d and 27th Surgical Hospitals were collocated in Chu Lai. The nearest evacuation hospitals in support were the 95th in Da Nang and the 67th and 85th in Qui Nhon. Although two surgical hospitals in Chu Lai provided good capability, the lack of a supporting evacuation hospital in the immediate vicinity caused major concern. Of the two evacuation hospitals collocated in Qui Nhon, the 67th functioned as a "pure" evacuation hospital while the 85th provided hospitalization for all PW patients generated in I Corps and II Corps North. Despite this latter mission, casualty loads did not fully justify two such hospitals in this locale. In Lai Khe there was a growing need for a surgical hospital to support the 1st Infantry Division. Phu Bai lacked an evacuation hospital in support of the 18th and 22d Surgical Hospitals.

d. The 2d Surgical Hospital at Chu Lai turned over its physical plant to the 312th Evacuation Hospital (Reserve Unit) upon arrival of the latter. (It should be understood that the 2d Surgical Hospital had been augmented with a clearing company, and the facility the hospital occupied was large enough to accommodate an evacuation hospital.) The 85th Evacuation Hospital at Qui Nhon turned over its facilities to the incoming 311th Field Hospital (PW) and relocated to Phu Bai. (This enabled the 311th to become functional pending the completion of permanent facilities now being constructed in the nearby Phu Thanh valley. When the 311th moves to Phu Thanh, its present facility will be released to the area commander.) The remaining reserve hospital, the 74th Field Hospital (PW), required the fewest changes in troop alignment. The 50th Clearing Company at Long Binh, which provided PW hospitalization for II Corps South, III Corps & IV Corps, relinquished its mission and its facilities to the 74th upon its arrival.

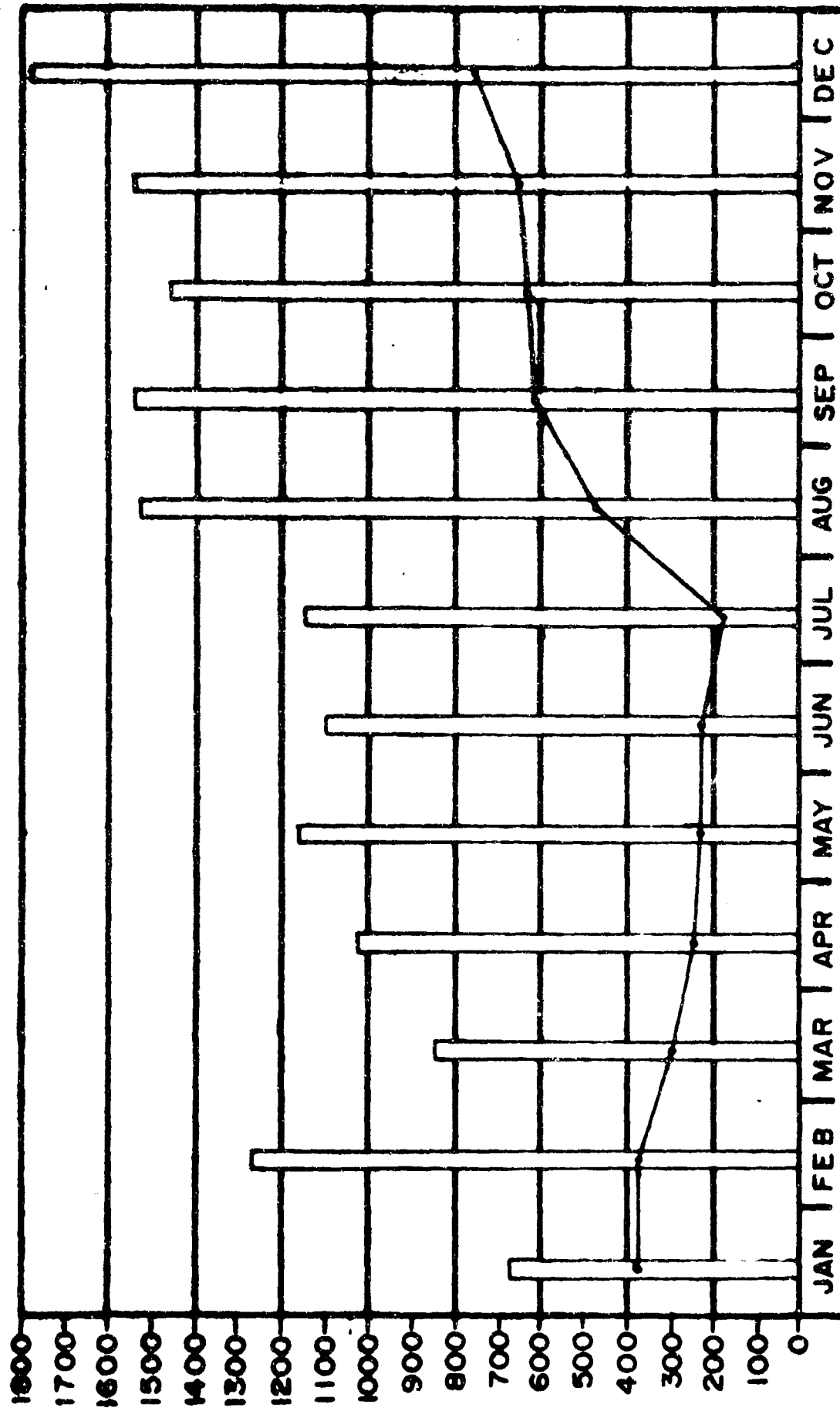
e. The actions described have been fully implemented except that the 85th Evacuation Hospital is presently operating only 100 beds. Construction, however, is underway for a complete facility at Phu Bai immediately adjacent to the present hospital site.



f. In summary, the major effort in this period has been refining our medical support posture by the relocation of several major in-country hospital units. The incoming reserve units provided the continuity of support essential to the accomplishment of this task.

ANNEX B

MILITARY CIVILIAN HEALTH ASSISTANCE

1. (U) USARV participation in the Medical Civic Action Program (MEDCAP) and the Civilian War Casualty Program (CWCP) continues to be refined. In December 1968, changes in policies and procedures for USARV programs were initiated to eliminate duplication and needless expenditure of resources. A command message was dispatched to the field revising and refining procedures. Of significance are those portions which establish a single coordinating channel, reduce three reports to one, and allow the treatment under the CWCP of all disabilities resulting from combat or related activities in Vietnam. These changes are consonant with MACV/USAID concepts and procedures.
2. (U) For the period 1 August 1968 - 1 February 1969, MEDCAP outpatient visits averaged 18,450 monthly. In addition, 60,987 were immunized, 3,340 were hospitalized in US Army facilities, and 1,869 hamlet health workers trained. Approximately 25,367 received dental treatments. See Appendix 1 for CWCP workload.
3. (U) In cooperation with Vietnamese government officials, limited veterinary assistance was provided to local nationals in support of their domestic animals. During the past six months, over 1,200 farm animals were given vaccinations and/or treated for diseases. In addition, in excess of 5,000 indigenous dogs were vaccinated against rabies. At the request of USAID, a veterinary officer was detailed to establish a vaccine distribution system for the Ministry of Agriculture, and livestock owners throughout Vietnam can now obtain critically needed biological supplies.



ADMISSIONS  PATIENTS REMAINING 

RVN CIVILIANS TREATED IN U.S. HOSPITALS

APPENDIX 1 To ANNEX B , MILITARY CIVILIAN HEALTH ASSISTANCE

ANNEX C

PERSONNEL

1. (U) ASSIGNMENT OF BOARD QUALIFIED AND BOARD CERTIFIED MEDICAL CORPS OFFICERS -- Effective 1 October 1968, the USARV policy regarding the assignment and reassignment of board qualified and board certified Medical Corps officers was changed. Prior to the change, fully trained specialists were assigned and reassigned directly to units by USARV. This tended to preempt command prerogatives and created a need for excessive coordination and record keeping on the part of the professional consultants. The current policy provides that all Medical Corps officers not assigned to tactical units be assigned to the 44th Medical Brigade. The Commanding General of the brigade then reassigns these officers to the medical groups with the recommendation of the consultant concerned. Group commanders are now responsible for the management of the physicians assigned to them. The implementing procedures for this policy eliminate much detailed coordination by the Surgeon's Office. Under the new system, group commanders can be more responsive to changes in tactical situations and make adjustments for R&A, leave, medical evacuation, and similar personnel changes. The change in the policy of Medical Corps officer assignments has permitted more efficient management of a critical resource and enabled medical commanders to better match resources with mission requirements.

2. (U) AIR FORCE MEDICAL CORPS -- Due to oversubscription to the Berry Plan, the Air Force attached 51 Medical Corps officers to USARV. Of these, 43 are general medical officers and 8 are specialists. Half of the general medical officers are assigned to tactical units and half are assigned to medical groups. After six months, these officers will be interchanged. The 8 specialists are assigned in the same manner as Army Medical Corps officers. The Air Force officers easily integrated into the Army units and their morale is high. They are making an outstanding contribution to our medical effort.

3. (U) STATUS OF PERSONNEL -- a. Officer: Medical Corps strength reached a low of 845 in mid August. This was a result of decreased output from the AMEDD basic course at Fort Sam Houston. By the end of the year the strength had increased to a satisfactory level for the existing tactical situation. The strength and quality of the Medical Corps in Vietnam continues to be sufficient to maintain high standards of medical support.

b. Enlisted: There was a critical shortage of enlisted technicians in MOS 91B in all grades in November and December 1968. During January 1969 there was a marked increase in input of EM with MOS's 91A and 91B. At the end of the month the posture in these MOS's was much improved but remains marginal.

ANNEX D

OPERATIONS

1. (U) RESPONSIBILITY OF USARV SURGEON VS CG, 44TH MEDICAL BRIGADE -- Medical staff actions, mid and long-range planning, and technical guidance to subordinate medical organizations are the responsibilities and functions of the USARV Surgeon. Day to day medical operations are controlled by the CG, 44th Medical Brigade and the tactical units' surgeons. The dual role of the CG, 44th Medical Brigade/USARV Surgeon and the capabilities of the two staffs to devote their efforts to separate areas of responsibility has proven to be more responsive to support requirements in the Republic of Vietnam.
2. (U) PROGRAM 6 -- Program 6 contains the last build-up of medical units into the Republic of Vietnam. The completion of the troop build-up in-country provided the opportunity to refine medical plans in the light of the actual situation (as opposed to the assumptions and estimates on which earlier plans had to be based). Earlier planners did so well that only one evacuation hospital and one air ambulance detachment were not needed and there were no shortages of medical capability. The two unneeded units have been deleted from Program 6.
3. (U) RESERVE UNITS -- Programs 5 and 6 planned for the activation and deployment of reserve medical units into the Republic of Vietnam. Units as listed in Appendix 1 have been deployed and are operational. Their rapid adjustment to RVN was due not only to the personal interest of the major subordinate commanders in the reception, operation and in-country orientation but also to the fine motivation and training of the units prior to deployment. The units are doing a fine job as an integral part of the Army Medical Department in Vietnam.
4. (U) HOSPITAL CONSTRUCTION -- Hospital construction continues according to plans and priorities. Construction of permanent treatment facilities began on 1 evacuation, 1 field and 1 surgical hospital. Fixed facilities for 3 MUST equipped hospitals will permit equipment to be issued to complete two mobile hospitals and to provide a better maintenance float (see paragraph 6). USARV Regulation 415-4 (U), Priorities of Hospital Construction at All Sites, 25 December 1968, revised construction standards for medical treatment facilities to that required for the best patient care. The new regulation formalizes standards for air-conditioning, water-borne sewage, forced water systems and improved sanitation. Appropriate standards for dispensaries and other medical facilities are being staffed.
5. (U) OPERATIONAL BEDS (Evaluation of Hospital Capabilities) -- With the exception of the two MUST hospitals designated to respond to contingency operations, the hospitals in Vietnam are fixed facilities. This degree of permanency has permitted a sophistication of facilities and equipment which, coupled with professional augmentations (TCE 8-500 Teams), results in most

evacuation and field hospitals being able to function as "quasi" small general hospitals. For the same reasons, some surgical hospitals have an upgraded mission in Vietnam. From the foregoing, it would appear that the 44th Medical Brigade hospitalization capability exceeds that expressed by TOE/MTOE authorization. The reverse was found to be true when hospital capability was evaluated for the ability to support sustained operations (see Appendix 2). The initial hospital capability survey, implemented by the Brigade, resulted in a critical command evaluation of sustained capability based on current resources of personnel, equipment and facilities. A comparison of results, indicated a capability below that of TOE/MTOE. The survey was not to prove or disprove the applicability of TOE capability statements to various type hospitals, but rather to establish a system in which the assessment of hospital capability is a command judgement based on current resources. The result is a realistic indicator of the 44th Brigade's ability to support sustained operations. This program is now the means by which hospital capabilities in RVN are assessed and reported (see Appendix 3).

6. (U) MUST CONCEPT -- a. While MUST equipment is an essential additive to the inventory of Medical Department assets, the concept as relates to improved mobility is somewhat at variance to the needs of Vietnam. Because hospitals support operations in Vietnam from fixed locations, the major planning consideration is a hospital site that is in a reasonably secure area. Proximity to tactical operations is generally a consideration only in the sense that the hospital must be within reasonable air evacuation time/distance. The only requirement for movement of hospitals is when major tactical forces shift to open new areas of operations, e.g., the large scale build-up of US Army forces in I Corps during the early part of 1968. MUST equipment is a link in such hospital relocations. Pending the construction of fixed facilities in new areas, MUST equipped hospitals provide the controlled environment and the other advantages needed to sustain USARV's excellent medical record, a capability far superior to that of a mobile non-MUST unit.

b. The future role is expected to be different. As fixed hospital construction is completed, the need for MUST diminishes. As good as MUST is, an air-conditioned fixed hospital is more suitable to Vietnam. During the report period, conversion to fixed facilities for three of the five MUST hospitals in-country began. During this conversion the three hospitals involved (3d, 22d and 45th Surgical Hospitals) will continue to operate in MUST; as construction progresses, the MUST will be withdrawn. To support contingency plans, the remaining two MUST equipped hospitals, the 18th Surgical Hospital in I Corps and the 2d Surgical Hospital in III Corps have the mission to remain mobile, subject to relocation on 72 hours notice. Both hospitals will receive additional MUST equipment as the equipment becomes available from the other three being converted.

7. (U) AREA SURVEY -- In November 1968, USARV tasked the 44th Medical Brigade to survey all medical activities (Army, Air Force and Navy) within the Republic of Vietnam. The purpose is to determine the medical support

for troop concentrations and the adequacy of such service. The results of this survey are to be used to develop a more effective medical support plan. The survey should be completed within the next 45 days.

8. (U) MEDICAL ELEMENTS NOT PART OF THE 44TH MEDICAL BRIGADE -- Almost 50% of USARV medical resources are in commands other than the 44th Medical Brigade. During the troop build-up, the USARV Surgeon's efforts were occupied primarily with Army-level (44th Medical Brigade) needs. However, since August 1968, assistance to the other medical elements has become a major effort and receives increasing attention from the USARV Surgeon's Office. In September 1968, as part of the effort, the first USARV Division and Separate Brigade Surgeons' Conference was held at HQ, USARV. Beginning with this conference, better cooperation, coordination and understanding have been fostered between the 44th Medical Brigade, the USARV Surgeon's Office, and the tactical elements. This has enhanced medical effectiveness to a large degree. The effort will continue and should cause further improvement.

9. (U) MEDICAL SUPPORT WITHIN THE DIVISIONS -- a. The optometry capability in Vietnam has been significantly increased during CY 1968. In August, the seven optometry officers were all assigned to 44th Medical Brigade medical treatment facilities. At the close of the year, 22 optometry officers were in-country: 14 assigned to division optometry sections and eight to Brigade facilities. Each division, except the 9th Infantry Division, now has a fully operational organic optometry section able to provide complete optometric care--vision examination and fabrication of spectacles in 1 to 1½ hours. Division commanders and senior staff officers are favorably impressed because placing the sections in the divisions has caused a significant reduction in the loss of "fox hole strength". One division has reported absences for optometry services were reduced from 600 man-weeks/month to 25.

b. MTOEs which increase the preventive medicine capabilities of all divisions are being processed. They add a sanitarian and 4 sanitary technicians to each division. Details are in Annex F.

c. Other studies to improve division medical support are underway.

10. (U) EVACUATION POLICY FOR HEPATITIS -- Formerly malaria and hepatitis patients were retained in-country as exceptions to the 30 day evacuation policy. Studies conducted in August 1968 revealed that the average hospitalization period for hepatitis was 44 days, 20% were over 60 days, and some were as long as 120 days, which caused USARV to support 100,000(-) non-productive man-days annually. To relieve USARV of this load, hepatitis is no longer an exception to the evacuation policy.

11. (U) T-DAY -- Planning for the post hostilities period began in September 1968. Initially the planning required relatively little time; as planning progressed it became, at times, a full time job for the Plans Officer. One basic troop list for medical support was developed and refined

by war gaming techniques. The refined list was incorporated into the overall USARV plan. Coordination with the MACV Command Surgeon's Office and the Chief Surgeon, USARPAC, insured complete understanding of USARV's medical concepts and philosophy. Planning factors utilized are contained in Appendix 4.

12. (U) RECAP-PAC -- a. The year 1968 saw the return of a few individual soldiers to United States authority, primarily by escaping from prison camps. The announcement of the release of 12 detainees in Cambodia in December 1968, caused detailed preparations to receive and process them for return to CONUS. Although, in fact they were not processed through Vietnam, the experience gained provided valuable insight and information which was incorporated into the USARV SOP. US Army RECAP personnel are placed in the control of CG, 44th Medical Brigade as soon as practicable. They are evacuated to the 24th Evacuation Hospital facility designated to process such recovered personnel. Here, subject to medical support, all in-country actions are carried out. Facilities for handling the recovered persons, for MI teams, for call to next of kin, and for handling the press have been provided at the hospital.

b. USARV Regulation 600-15, Processing of Missing in Action, Returned, Exchanged and Escaped Personnel (U), is being revised to publish the complete plan developed for processing returnees. The USARV Surgeon is developing an SOP for handling RECAP-PAC personnel which can be applied to any USARV medical facility. As a follow-on, plans for handling large numbers of returnees (similar to Big Switch) are being prepared. All of these actions should be completed early in CY 1969.

13. (U) RADIO COMMUNICATIONS -- a. The successful accomplishment of the 44th Medical Brigade's mission is directly related to its ability to communicate. No other major medical command in the history of the US Army has enjoyed the communication capabilities of this Brigade. There are two primary nets within the Brigade, the single side band (SSB) and the Dust-off radio nets.

b. During CY 68, Department of the Army approved a Brigade request for thirty-eight AN/FRC-93 Collins SSB radios. Thirty of these radios have been received and are utilized in a Brigade net and four internal medical group nets (see Appendix 5). The primary use of the SSB net is to regulate patient flow within the Brigade and to pass command and control message traffic. Through the SSB Brigade net, the Brigade Commander now has reliable communications with the units most distant from his headquarters.

c. Dust-off radio nets consist of both FM and UHF radios (see Appendix 6). The FM net is composed of VRC-46's at the local Dust-off Control Stations and ARC-54's in the aircraft. The UHF net is composed of VRC-24's at the local Dust-off Control Station and VRC-15's in the aircraft. The primary FM net is used to receive and relay Dust-off missions and for command and control of the aircraft. The UHF net is a back-up system for the FM net. The alternate FM net (Appendix 7) is used to relay the nature of

the casualties aboard the aircraft to the medical groups who in turn notify the aircraft commander as to the destination hospital.

14. (U) AIR AMBULANCE OPERATIONS (DUST-OFF) -- a. Air ambulance operations during the period remained at a constant, relatively high level. High months were August with 16,915 patients evacuated by Dust-off helicopters and September with 16,776. Total patients evacuated for the period 1 August 1968 through 27 January 1969 was 90,399 (see Appendix 8).

b. The 44th Medical Brigade's ability to provide aeromedical evacuation support within South Vietnam increased significantly with the arrival of 4 medical detachments (RA) in November and December 1968. With the new units the Brigade authorization increased to 116 helicopters, constituted by 2 medical companies (Air Ambulance) and 11 medical detachments (RA). Two of the units are located in I Corps Tactical Zone (CTZ) at Da Nang and Camp Evans, one at Phu Hiep in II CTZ South and the other unit at Dong Tam in IV CTZ. Each medical group is now self sufficient in aeromedical evacuation capability. Previously, up to 6 or 7 helicopters per day were on loan between medical groups to provide sufficient coverage in areas with limited aeromedical evacuation resources.

c. Although it is premature to draw any definite conclusion, it appears that the arrival of the new units lead to a higher percentage of aircraft available for missions. The December availability rate was 78% compared to 67% for November. The new units' arrival placed 24 nearly new helicopters into the inventory and maintenance problems on newer aircraft are generally less than on older aircraft. However, the arrival of the new units also reduced field sites and blade-time on individual aircraft. This enabled air ambulance units to establish better maintenance schedules and allowed more maintenance time.

d. Throughout the period Dust-off helicopters were the targets of hostile fire, some being hit almost daily. Nineteen crewmembers were killed and 48 wounded. In addition, 16 patients were killed and 6 received additional wounds while being evacuated. Despite the hazards involved, patients continue to be evacuated.

e. The period closes with the Brigade's ability to provide aeromedical evacuation support considerably strengthened. All areas of South Vietnam are now supported in depth by air ambulance units.

RESERVE MEDICAL UNITS

<u>UNIT</u>	<u>DATE OF ARRIVAL</u>
650th Med Det (KJ)	27 Aug 68
316th Med Det (NC)	13 Sep 68
378th Med Det (KE)	19 Sep 68
305th Med Det (KB)	19 Sep 68
472d Med Det (RB)	26 Sep 68
312th Evac Hosp	26 Sep 68
482d Med Det (GD)	28 Sep 68
313th Med Det (KA)	30 Sep 68
889th Med Det (KA)	30 Sep 68
311th Fld Hosp	11 Oct 68
74th Fld Hosp	15 Oct 68

APPENDIX 1 to ANNEX D, OPERATIONS (RECEPTION OF RESERVE UNITS)

(17)

DEPARTMENT OF THE ARMY
HEADQUARTERS, 44TH MEDICAL BRIGADE
APO SF 96384

AVBJ PG

4 August 1968

SUBJECT: Evaluation of Hospital Capabilities

Commanding Officer, 43d Medical Group, APO 96240
Commanding Officer, 55th Medical Group, APO 96238
Commanding Officer, 67th Medical Group, APO 96337
Commanding Officer, 68th Medical Group, APO 96491

1. The current number of operating beds for hospitals of the 44th Medical Brigade is based on TOE/MTOE authorizations. Such accounting overstates our true capability. To provide this headquarters with a more realistic planning basis, it is requested that each hospital commander evaluate his hospital capabilities (operational beds), taking into consideration current assigned staffing, facilities, equipment and other limiting factors. Following these criteria, request a one time narrative discussion and report as to the total number of operating beds, categorized as medical and surgical beds, that each hospital commander believes he could support for a sustained period of two to four weeks. In addition, request the holding capabilities of each hospital.

2. Sample report attached as inclosure #1.


3. Although this is a one time evaluation report, it is expected that group and hospital commanders will continue to evaluate hospital capabilities and when in their opinion there is variance of 10% above or below that approved by this headquarters a reevaluation will be submitted.

4. I desire command interest in these evaluations and that replies reach this headquarters, NLT 23 August 1968.

FOR THE COMMANDER:

2 Incl
as

/s/Robert D. Pillsbury
/t/ROBERT D. PILLSBURY
Colonel, MC
Deputy Commander

A true copy

THOMAS J. GORDON
MAJ, NBC
Asst Adjutant

APPENDIX 2 to ANNEX D, OPERATIONS (OPERATIONAL BEDS)

(18)

S A M P L E

AVBJ PO () 1st Ind

SUBJECT: Commander's Evaluation on Operational Bed Capability

Headquarters, _____ Medical Group, APO 96000 _____ August 1968

TO: Commanding General, 44th Medical Brigade, APO 96348

1. Concur with evaluation as submitted with the following exception: Operating beds provided by augmenting units should be 20 medical beds and 0 surgical beds.
2. Analysis of this hospital's in-country evacuations, daily average beds occupied, and experiences during Tet and the May offensives confirm recommended operating bed capability.

JOHN T. WILLIAMS
Colonel, MC
Commanding

AVBJ XI () 2d Ind

SUBJECT: Commander's Evaluation on Operational Bed Capability

Headquarters, 44th Medical Brigade, APO 96384 _____ August 1968

TO: Commanding Officer, _____ Medical Group, APO 96000

1. Concur with evaluation as indorsed.
2. The _____ Surgical Hospital is designated as having a capability of 70 operational beds (35 medical, 35 surgical) and 20 holding beds.

SPURGEON KEEL
Brigadier General, MC
Commanding

S A M P L E

Incl 1

(19)

DEPARTMENT OF THE ARMY
SURGICAL HOSPITAL
APO 96000

AVBJ PO

___ August 1966

SUBJECT: Commander's Evaluation on Operational Bed Capability

Commanding Officer
___ Medical Group
APO 96000

1. Hospital Designation: ___ Surgical Hospital.
2. Augmenting Unit Designation: 1st Platoon, ___ Clearing Company.
3. Beds currently authorized by TOE/MTOE excluding augmenting unit: 60.
 - a. Medical Beds: NA
 - b. Surgical Beds: 40.
 - c. Holding Beds: 20.
4. Actual operating beds available per Commander's Evaluation excluding augmenting unit: 50.
 - a. Medical Beds: 15.
 - b. Surgical Beds: 35.
5. Holding beds available per Commander's Evaluation excluding augmenting unit: 0.
6. Primary limiting factor(s) causing difference between para 3 and 4: Despite the availability of equipment to support 60 operating beds as authorized by TOE, the shortage of several key professional personnel and enlisted personnel indicates that this hospital could provide adequate support to 50 operating beds. Because of the absence of general medical support in this area, it has been necessary for this hospital to assume an additional mission of general medical support and, as a result, 15 surgical beds are normally utilized as medical beds. These beds, however, can be used as surgical beds if an influx of surgical patients dictates. In addition, combat experience in this area and analysis of surgical backlogs further document a 50 operating bed capability.

SAMPLE

(20)

AVBJ PO

August 1968

SUBJECT: Commander's Evaluation of Operational Bed Capability

7. Beds provided by augmenting unit per TOE/HTOE: 80.

a. Medical Beds: 40.

b. Surgical Beds: 40.

8. Operating beds provided by augmenting units per Commander's Evaluation: 20.

a. Medical Beds: 5.

b. Surgical Beds: 15.

9. Holding beds provided by augmenting units per Commander's Evaluation: 20.

10. Primary limiting factor(s) causing difference between para 7 and 8. Real estate limitations and personnel shortages prevented establishment of the complete 80-bed clearing platoon. A portion of the real estate originally intended for the clearing platoon was required for troop billeting and supply storage areas. Additional equipment and personnel provided by the clearing platoon did allow the establishment of 5 additional medical and 15 additional surgical operating beds. However, these beds were incorporated into the surgical hospital because of better treatment capabilities. The clearing platoon can provide 20 holding beds for patients requiring short-term convalescence or awaiting further evacuation.

11. Other Discussion: This hospital with its augmenting unit is capable of supporting 70 operating beds for a sustained period of 2-4 weeks and 20 holding beds. With the appropriate personnel staffing and available real estate, the number of operating beds could be increased to 85. There is no need to increase the number of holding beds.

JOHN H. JONES
LTC, MC
Commanding

2
SAMPLE

(21)

HOSPITAL CAPABILITIES SURVEY

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5 OPERATING BEDS		COLUMN 6
UNIT	LOCATION	TOT	CLR AUG	TOTAL	SURG	HOLD BEDS
2 Surg /1	Chu Lai	60	240 563 Med Co (CLR)	150	100	50
18 Surg	Quang Tri	60	80 3d Plt 616 Med Co (CLR)	70	50	20
22 Surg	Phu Bai	60	80 2d Plt 616 Med Co (CLR)	80	45	35
27 Surg	Chu Lai	60	240 520 Med Co (CLR)	140	95	45
95 Evac	Da Nang	400	N/A	320	200	120
67 F c	Qui Nhon	400	N/A	400	261	139
71 Evac	Pleiku	400	N/A	400	200	200
85 Evac	Qui Nhon	400	N/A	340	240	100
17 Field	An Khe	100	N/A	100	60	40
8 Field	Nha Trang	400	N/A	365	176	189

(22)

1861 2

(23)

COLUMN 1 UNIT	COLUMN 2 LOCATION	COLUMN 3 TGS	COLUMN 4 CLR AUG	COLUMN 5 OPERATING BEDS		COLUMN 6 HOLD BEDS
				TOTAL	SURG	MED
91 Evac	Tay Hoa	400	N/A	300	180	120
6 CC	Cam Ranh Bay	1300	N/A			(1300)/2
3d Field	Saigon	400	N/A	292	146	146
3d Surg	Dong Tam	60	N/A	45	35	10
7 Surg	Xuan Loc	60	N/A		37	15
45 Surg	Tay Ninh	60	N/A	40	40	0
12 Evac	Cu Chi	400	N/A	317	261	56
24 Evac	Long Binh	400	N/A	328	211	117
29 Evac	Can Tho	400	N/A	328	191	137
36 Evac	Vung Tau	400	N/A	400	343	57
93 Evac	Long Binh	400	N/A	320	220	100
TOTALS PER INITIAL SURVEY		5960	6600/3	4787	3091	1696
						440

CURRENT CHANGES

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5		COLUMN 6
UNIT	LOCATION	TOE	CLR AUG	TOTAL	OPERATING BEDS SURG	HOLD BEDS
312 Evac/L4	Chu Lai	400	N/A	400	—	—
USAH PROV/L5	Phu Bai	100	N/A	100	—	—
74 Field/L6	Long Binh	250	N/A	250	—	—

L1 Replaced by 312 Evac, see note L4

L2 Convalescent Beds

L3 Column 3 plus column 4

L4 Became operational 1 Oct 68, evaluation pending

L5 Became operational 14 Oct 68, evaluation pending

L6 Became operational 14 Oct 68, evaluation pending

(24)

HOSPITAL BEDS STATUS - 1968 (U)

	<u>JAN</u>	<u>FEB</u>	<u>MAR</u>	<u>APR</u>	<u>MAY</u>	<u>JUN</u>	<u>JUL</u>	<u>AUG</u>	<u>SEP</u>	<u>OCT</u>	<u>NOV</u>	<u>DEC</u>	<u>AVERAGE</u>
Beds Operational	4305	4350	4265	4525	4905	4905	5065	5365	4787	5287	5597	5283	4887
Average Daily Beds Occupied (All patients)	2465	2442	2376	2583	2689	2622	2680	2785	2597	2968	3176	3165	2712
Percent of Beds Occupied	57.3	56.1	55.7	57.1	54.8	53.5	52.9	51.9	54.3	56.1	56.7	59.9	55.5

(25)

APPENDIX 3 TO ANNEX D, OPERATIONS (OPERATIONAL BEDS)

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USARV T-DAY PLANNING FACTORS (U)

1. (SNF) World-wide shortages of medical personnel (particularly MC and ANC) require that USARV medical treatment elements be kept to minimum essential requirements. Wherever possible, evacuation capability must be used to reduce the number and size of facilities which require MC and ANC staffing.
2. (SNF) There must be no needless duplication of capability; however, since most reduced strength units lack balance, units are planned to be at full MTOE strength unless balanced reduced capability can be achieved by deleting an organizational element, e.g., delete one hospitalization unit from a field hospital, or by using a G-series TOE lower level.
3. (SNF) Unnecessary headquarters are not included. Each area surgeon (usually the hospital commander) will control all USARV medical units in his area.
4. (SNF) Medical organizations not organic to combat and combat support units are organized into an appropriate medical command (USA Med Comd Vietnam) (USAMCV) (one Med Gp HQ) separate from any logistic/support command and immediately subordinate to that headquarters exercising overall US Army command. The staff surgeon at that headquarters also commands the medical command.
5. (SNF) To avoid relocating units during withdrawal so far as possible, units to remain at specific locations in-country are those already in place.
6. (SNF) US Army medical troops support all MAAGV forces remaining in-country after roll-up; support all US Army residual, shortfall, and roll-up forces; support US Navy residual and shortfall forces (except those afloat) in I CTZ and US Navy residual, shortfall, and roll-up forces in II, III and IV CTZs; and provide back-up to FVMAF residual forces (primarily hospitalization). AF provides medical support to AF residual, shortfall, and roll-up forces. Support to a joint NVA/SVN/US Armistice Commission may require US Army medical forces above those now planned. Force strength of Armistice Commission now unknown.
7. (SNF) Headquarters, 44th Medical Brigade withdraws when any one of the following occurs (lettered in probable order of occurrence):
 - a. Medical force is reduced to two medical groups.
 - b. HQ USARV stands down under Alternative C.
 - c. MAAGV Surgeon assumes command under Alternatives A, B, D & E.

(26)

APPENDIX A to ANNEX D. OPERATIONS

DOWNGRADED AT 3 YEAR INTERVALS;
DECLASSIFIED AFTER 12 YEARS.
DOD DMR 5200.10

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4. A general officer is no longer required and medical force is small enough to be controlled directly by USARV. (A colonel could command 44th Medical Brigade if medical force strength requires brigade headquarters.)
8. (CMF) Unit strengths and capabilities are MTOE strengths and capabilities, unless otherwise indicated.
9. (SNF) Roll-up is from west to east and medical units close as supported forces redeploy.
10. (SNF) After closing, each redeploying medical unit has 45 days for staging.
11. (SNF) Combat and combat support elements retain their organic medical capability until stand down and provide area medical support to collocated troops without organic capability.
12. (SNF) MEDCAP activities conducted by USARV phase down between T-Day and R-Day as medical units close to prepare for redeployment. This is a gradual phasing, with MAAGV/USAID assuming responsibility for providing civilian health assistance effort in cooperation with GVN.
13. (SNF) Civilian War Casualty Program (CWCP) phases out as medical units close for redeployment. Responsibility for this program is transferred to GVN through MAAGV/USAID.
14. (SNF) Facilities to be transferred to RVNAF and USAID remain in USARV control until occupying units redeploy. Before T-Day, GVN/USAID will identify desired facilities to be transferred.
15. (SNF) Expendable medical materiel will be transferred to RVNAF and USAID with RVNAF having first priority. Medical equipment will be redistributed in accordance with priorities established by DA and PACOM. Medical technical equipment will not be transferred to RVNAF and USAID which is beyond their capability to maintain, operate, and utilize. DA and PACOM will establish redistribution priorities on or before T minus 30 days.
16. (SNF) Special teams control roll-up in each zone. These same teams provide a reception capability for reentry of medical units until roll-up is complete.
17. (SNF) At each stage until roll-up is complete, reentry support for returning tactical units is provided by maintaining a hospital bed capacity excess to required operating beds. USARPAC and DA provide personnel by air to staff the excess capacity concurrently with reentry of tactical units. USARPAC and DA retain medical reentry units for prompt deployment. During reentry, USARPAC sets RVN evacuation policy at 15 days.
18. (CMF) Except during a reentry, evacuation policy is 30 days.

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19. (SNF) MAAGV is at Long Binh.
20. (SNF) All MII-MAP or other medical advisory teams are additional to USARV medical troop list and USARV medical strength.
21. (SNF) Medical personnel (including Dental Surgeon, Preventive Medicine Officer, Veterinarian, and professional consultants) to staff the MAAGV Surgeon's Office or US Army Component Surgeon's Office are excluded from the medical troop list and medical troop ceiling in USARV planning.
22. (SNF) Air Force provides a casualty staging facility (CSF) at Tan Son Nhut Air Base or Bien Hoa Air Base.
23. (SNF) Air Force provides in-country fixed-wing aeromedevac capability sufficient (two C-130 or three C-7) for at least two "milk-runs" per week and for special calls; or Air Force turns over equivalent capability to the Army to accomplish mission.
24. (SNF) The Air Force hospital facility at Cam Ranh Bay is available for use by USARV after roll-up except in Alternative C.
25. (SNF) The Navy provides medical support to Navy/Marines in I CTZ until roll-up is complete and reinserts medical support if Navy/Marine forces reenter.
26. (SNF) One hospital ship remains on-station in South China Sea until roll-up is complete.
27. (SNF) Offshore medical facilities meet USARV support requirements during each phase of the withdrawal. In the event hostilities resume, the offshore hospitals are capable of receiving immediately the casualties which may be generated. USARV hospital phase-down is coordinated with USARV phase-down.
28. (SNF) Alternative summary:

<u>ALTERNATIVE</u>	<u>MAJOR FORCE REDEPLOYMENT COMPLETE BY</u>	<u>EQUIPMENT WITHDRAWN BY</u>	<u>RESIDUAL</u>
A	R Plus 6	R Plus 9	MAAG 1/
B	R Plus 12	R Plus 12	MAAG 2/
C	R Plus 12	R Plus 12	MAAG plus US/Free World Combat Forces 2/

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<u>ALTERNATIVE</u>	<u>MAJOR FORCE REDEPLOYMENT COMPLETE BY</u>	<u>EQUIPMENT WITHDRAWN BY</u>	<u>RESIDUAL</u>
D-I	R Plus 6	R Plus 9	MAAG plus US short- fall units to cover shortfalls in RVNAP capability until Phase II goals of RVNAP Im- provement and Modern- ization Program are achieved. 1/ 2/
D-II	R Plus 12	R Plus 12	
E (1966 Manila Communique)	R Plus 6	R Plus 9	MAAG 3/

1/ Phase 0 = 6 months; Phases I thru VI = 1 month each; after VI = 3 months to complete roll-up.

2/ Same as 1/ except Phases I thru VI = 2 months each; no roll-up period after VI.

3/ Phase 0 in length is less than 6 months, T-Day could be R-Day; Phases I thru VI = 1 month each; after VI = 3 months to complete roll-up.

29. (SNF) If medical plans are such that phase-down could begin on T-Day and roll-up complete in 9 months, then all alternatives can be met.

30. (SNF) Supported Force Strengths Estimated as of 15 Dec 68: Phasing of MACV to MAAGV and phase-down of Navy unknown. Therefore total supported strength estimates for Phases I to VI are tentative pending receipt of MACV/ Navy phasing. Shortfall force distribution (Alternative D) is assumed pending determination of proposed location. Troop concentrations marked with an asterisk receive dispensary/aid station/clearing station support from medical elements organic to tactical residual/roll-up units.

TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	PVNAP	TOTAL FOR HOSPITAL & EVAC ONLY
	I	UNK	325,000	UNK			
	II		309,000				
	III		281,000				
	IV		229,000				

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TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWKAP	TOTAL FOR HOSPITAL & EVAC ONLY
	V		193,000				
Alternative C:							
	VI	38,970	89,713	3,723	132,406	10,396	142,802
Alternative D-I:							
	VI	38,970	65,819	5,248	110,037		110,037
	R+9	38,970	15,240	3,723	57,933		57,933
Alternative D-II:							
	VI	38,970	15,240	3,723	57,933		57,933
Alternatives A & E:							
	VI	38,970	50,579	1,525	91,074		91,074
	R+9	38,970			38,970		38,970
Alternative B:							
	VI	38,970			38,970		38,970
I CTZ:							
(Log Island A-- (Da Nang))							
	I		51,500				
	II		41,500				
	III		38,500				
	IV		15,500				
	V		9,500				
Alternative C:							
	VI	5,560	547	260	6,367		6,367
Alternative D-I:							
	VI	5,560	7,535	260	13,355		13,355

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TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWMAP	TOTAL FOR HOSPITAL & EVAC ONLY
	R+9	5,560	2,299	260	8,119		8,119
Alternative D-II:							
	VI	5,560	2,299	260	8,119		8,119
Alternatives A & B:							
	VI	5,560	5,236		10,796		10,796
	R+9	5,560			5,560		5,560
Alternative B:							
	VI	5,560			5,560		5,560

Distribution of Final Supported Strength: I CTZ:

Alternatives:			
	A - B - E	C	D
Quang Tri	221	221	221
Hue/Phu Bai	503	503	503
Da Nang	4,298	5,105	6,857
Chu Lai	157	157	157
Quang Ngai	381	381	381

II CTZ:

TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWMAP	TOTAL FOR HOSPITAL & EVAC ONLY
(Log Island B (Qui Nhon) & Log Island C (Cam Ranh))							
	I		120,000				
	II		118,000				

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SECRET NOFORN

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TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWMAP	TOTAL FOR HOSPITAL & EVAC ONLY
	III		99,000				
	IV		94,000				
	V		88,000				
Alternative C:							
	VI	10,556	48,208	1,044	59,808	3,589	63,397
Alternative D-I:							
	VI	10,556	29,072	1,786	41,414		41,414
	R+9	10,556	6,557	1,044	18,177		18,177
Alternative D-II:							
	VI	10,556	6,557	1,044	18,177		18,177
Alternatives A & E:							
	VI	10,556	22,495	742	33,793		33,793
	R+9	10,556			10,556		10,556
Alternative B:							
	VI	10,556			10,556		10,556

Distribution of Final Supported Forces: II CTZ:

	Alternatives:		
	A - B - E	C	D
Kontum	206	206	206
Qui Nhon	2,827	13,874	4,426
An Khe		23,771*	
Phu Bat		456	
Floika	2,294	2,294	2,294
Phu Bon	<u>87</u>	<u>87</u>	<u>87</u>
Total Log Island B	5,414	40,608	7,013

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Alternatives:

	A - B - E	C	D
Tuy Hoa	196	3,577*	483
Darlac	335	335	335
Cam Ranh	2,220	13,025*	6,994*
Nha Trang			674
Quang Duc	102	102	102
Tuyen Duc	107	107	107
Phan Rang	1,900	5,281*	2,187*
Lam Dong	114	114	114
Phan Thiet	<u>168</u>	<u>168</u>	<u>168</u>
Total Log Island C	5,142	22,709	11,164

III CTZ:

TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWMAP	TOTAL FOR HOSPITAL & EVAC ONLY
(Log Island D (Saigon))							
	I		123,000				
	II		119,000				
	III		113,000				
	IV		107,000				
	V		90,000				
Alternative C:							
	VI	16,248	40,958	588	57,794	6,807	64,601

SECRET NOFORN

TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWMAF	TOTAL FOR HOSPITAL & EVAC ONLY
Alternative D-I:							
	VI	16,248	26,258	1,371	44,077		44,077
	B+9	16,248	4,405	588	21,241		21,241
Alternative D-II:							
	VI	16,248	4,405	588	21,241		21,241
Alternatives A & B:							
	VI	16,248	21,953	783	38,884		38,884
	B+9	16,248			16,248		16,248
Alternative B:							
	VI	16,248			16,248		16,248

Distribution of Final Supported Forces: III CTZ:

	Alternatives:		
	A - B - E	C	D
Phuoc Long	148	148	148
Long Khanh	310	310	310
Binh Tuy	121	121	121
Binh Long	145	145	145
Phuoc Vinh	355	355*	355*
Bien Hoa/Long Binh	8,177	46,151*	12,660*
Beaumont		3,722*	
Vung Tau	188	6,507	423
Tay Ninh	140	140	140
Cu Chi	311	311*	311*

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Alternatives:

	A - B - E	C	D
Gia Dinh	1,220	1,220	1,220
Saigon/Tan Son Nhut	4,689	5,227	5,227
Long An	244	244	244

IV CTZ: (Redeploys through Log Island D. IV CTZ troops redeploy in Phase IV and later)

TOTAL:	At End of Phase	MACV	ARMY	NAVY	TOTAL FOR ALL MED SPT	FWMAP	TOTAL FOR HOSPITAL & EVAC ONLY
	III		30,000				
	IV		12,000				
	V		5,000				
Alternative C:							
	VI	6,606		1,831	8,437		8,437
Alternative D-I:							
	VI	6,606	2,954	1,831	11,391		11,391
	B+9	6,606	1,959	1,831	10,396		10,396
Alternative D-II:							
	VI	6,606	1,959	1,831	10,396		10,396
Alternatives A & E:							
	VI	6,606	995		7,601		7,601
	B+9	6,606			6,606		6,606
Alternative B:							
	VI	6,606			6,606		6,606

Distribution of Final Supported Forces: IV CTZ:

Alternatives:

	A - B - E	C	D
Kien Tuong	86	86	86

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Alternatives:

	A - B - E	C	D
Dong Tam/My Tho	436	818	816
Ben Tre	190	190	190
Kien Phuong	170	170	170
Sa Dec	217	287	287
Ving Long	227	227	227
Vinh Binh	180	180	180
Chan Duc	134	184	184
An Giang	101	101	101
Can Tho/Binh Thuy	3,623	4,173	6,132
Soc Trang	201	201	201
Kien Giang	297	237	297
Chuong Thien	124	124	124
Bac Lieu	314	314	314
An Xuyen	148	148	148
Go Cong	108	108	108
VNN Riverine		829	829

31. (SNP) Required hospital beds are computed from in-country NBI and disease experience during April - September 1968 and average NBI and disease patient stay for the same period (30 day evac policy). To provide for dispersion and for resumption of hostilities, the ratio of NBI and disease to battle casualties from November 1966 - April 1967 (a period of buildup comparable to reentry) is used. This ratio is 1.0 to 0.2. The dispersion factor therefore is 1.2. Admissions/1000/day for DNBI are 1.13; accumulation factor is 8.12 (30 day evac policy). Required hospital beds/1000 strength are: $(1.13 \times 8.12 \times 1.2 = 11.01)$ or 11 beds/1000 supported strength.

32. (SNP) Total final required operating beds, not allowing for troop deployment and evacuation time-distance factors are:

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Alternatives:

A, B & E

D

G

429

637

1,570

33. (SNF) Required operating beds to support by phase are:

<u>AT END OF PHASE</u>	<u>I OTZ 1/</u>	<u>II OTZ</u>	<u>III OTZ</u>	<u>IV OTZ 1/</u>	<u>TOTAL</u>
I	560	1320	1355	340	3575
II	450	1300	1320	330	3400
III	425	1090	1245	330	3090
IV	170	1035	1180	135	2520
V	105	970	990	60	2125
Alt C: VI	70	700	715	85	1570
Alt D-I:					
VI	150	455	485	120	1210
R+9	90	200	225	120	635
Alt D-II: VI	90	200	225	120	635
Alt A & B:					
VI	120	370	425	85	1000
R+9	60	115	180	75	430
Alt B: VI	60	115	180	75	430

1/ Not necessarily located in I and IV OTZ.

34. (SNF) Forty hospital beds are required to support US civilians (Embassy, USAID, COORDS, VIP, and other authorized civilians), of which only 15 beds are required in Saigon. The mode (1 Sep - 15 Dec 68) of all US civilians in USARV hospitals is 40; the mode of US civilians hospitalized in the same period in Saigon is 15.

35. (SNF) To minimize administrative spaces and maximize patient care spaces, areas of low population density (when helicopter time-distance does not preclude an acceptable time lag to reach a hospital) are supported by dispensaries with resuscitative capability rather than hospitals.

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36. (SNF) The 8th Field Hospital at Nha Trang supports Cam Ranh Bay from Nha Trang or supplants at Cam Ranh Bay the 12th Air Force Hospital there now.

37. (SNF) Certain medical units required at Qui Nhon and An Khe under Alternative C displace to Da Nang and Cam Ranh Bay when residual force is withdrawn.

38. (SNF) Whenever possible, dentists organic to units support in lieu of KJ teams.

39. (SNF) Medical supply elements are based on tonnage handled, equipment density, and area support.

40. (SNF) Dispensaries support only troop densities of 1000⁺ or greater where troops are without organic dispensary type support.

41. (SNF) TOE/MTOE 8-500 detachments:

a. RE detachments provide short-haul, large load ground evacuation; EB detachments provide other ground evacuation. RA detachments provide aeromedical evacuation.

b. JB detachments support ports and procurement points.

c. ID detachments and IE detachments depend on supported US forces' dog population.

d. OA (Aviation) detachments are included in medical troop list.

e. Other detachments provide only required specialties not available in non-8-500 units.

42. (SNF) Medical laboratory and preventive medicine units do no pure research because that is a WRAIR mission. USAID advises and supports VN civilian lab and preventive medicine effort.

43. (SNF) Dental support is planned at 1 dental officer/1000 supported troops, including dentists organic to non-dental units.

44. (SNF) Preventive medicine support is planned using the following factors plus the base element required to maintain effectiveness in the field teams.

	Small Post (Strength 250(+)) (Man - years)	Large Post (Strength: 1000(+) troops) (Man - years)
Control Team:	EM: 0.4/post Off: 0.04/post	EM: 0.5/post + 0.2/1000 Off: 0.06/post + 0.02/1000

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Environmental Team: EM: 0.5/post EM: 0.6/post + 0.25/1000
 Off: 0.06/post Off: 0.14/post + 0.05/1000

45. (SNP) Planned location and medical elements of FVMAF:

Location	Strength	FVMAF Medical Elements
Qui Nhon	ROK 3,577	Med Co
Beareat	THAI 2,102	Med Co
Hui Dat (near Vung Tau)	AUS/NZ 4,705	Med Co Equivalent

46. (SNP) Roll-up team composition and strength:

a. Composition of Battalion Command and Control Teams - 3 Teams
 TOE 8-1260; Str: 16 each; Total Str: 48.

CO (MSC; Med Bn IC, MOS 3506, becomes team commander)

S1

S3

S4

Pers Staff NCO and Clk

Opn Sgt and Commo Chief and Clk

Supply Sgt and Med Supply Sgt and Clk

Mnt Sgt, Wheeled Vehicle Mechanic, Armorer and Clk

Total personnel: 16

Location: Da Nang - roll-up medical forces in I CTZ

Qui Nhon - roll-up medical forces in II CTZ

Long Binh - roll-up medical forces in III and IV CTZ

Unit: 74th Med Bn at Da Nang, 70th Med Bn at Qui Nhon and 61st Med Bn at Long Binh

b. Composition of Medical Depot Teams - TOE 8-667E; Str: 59.

(1) Team #1 at Da Nang to roll-up medical forces in I CTZ:

Med Equip Repair Tech	WO 202A	1
Storage Officer	LT 4490	1
Sr Med Equip Repair	35030	1
Med Equip Repair	35020	1
Med Sup Storage Supv	76J40	1
Med Sup Sp	76J20	2
Packing-Crating Sp	76V20	1
Warehouseman	76A10	3

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(2) Team #2 at Qui Nhon to roll-up medical forces in II CTZ:

Med Equip Repmn Tech	WO 202A	1
Storage Officer	LT 4490	1
Sr Med Equip Repmn	35G30	1
Med Equip Repmn	35G20	2
Med Sup Storage Supv	76J40	2
Med Sup Sp	76J20	2
Packing-Crating Sp	76V20	1
Warehouseman	76A10	3
		<u>13</u>

(3) Team #3 at Long Binh to roll-up medical forces in III and IV CTZ:

Med Equip Repmn Tech	WO 202A	2
Storage Officer	LT 4490	2
Sr Med Equip Repmn	35G30	2
Med Equip Repmn	35G20	5
Med Sup Storage Supv	76J40	5
Med Sup Sp	76J20	8
Packing-Crating Sp	76V20	2
Warehouseman	76A10	9
		<u>35</u>

47. (SNF) As reflected in the revised troop lists, DA and USARPAC authorize the following troop unit changes effective T-Day and prepare pre-cut general orders implementing the changes for issue on T-Day:

Alternative C

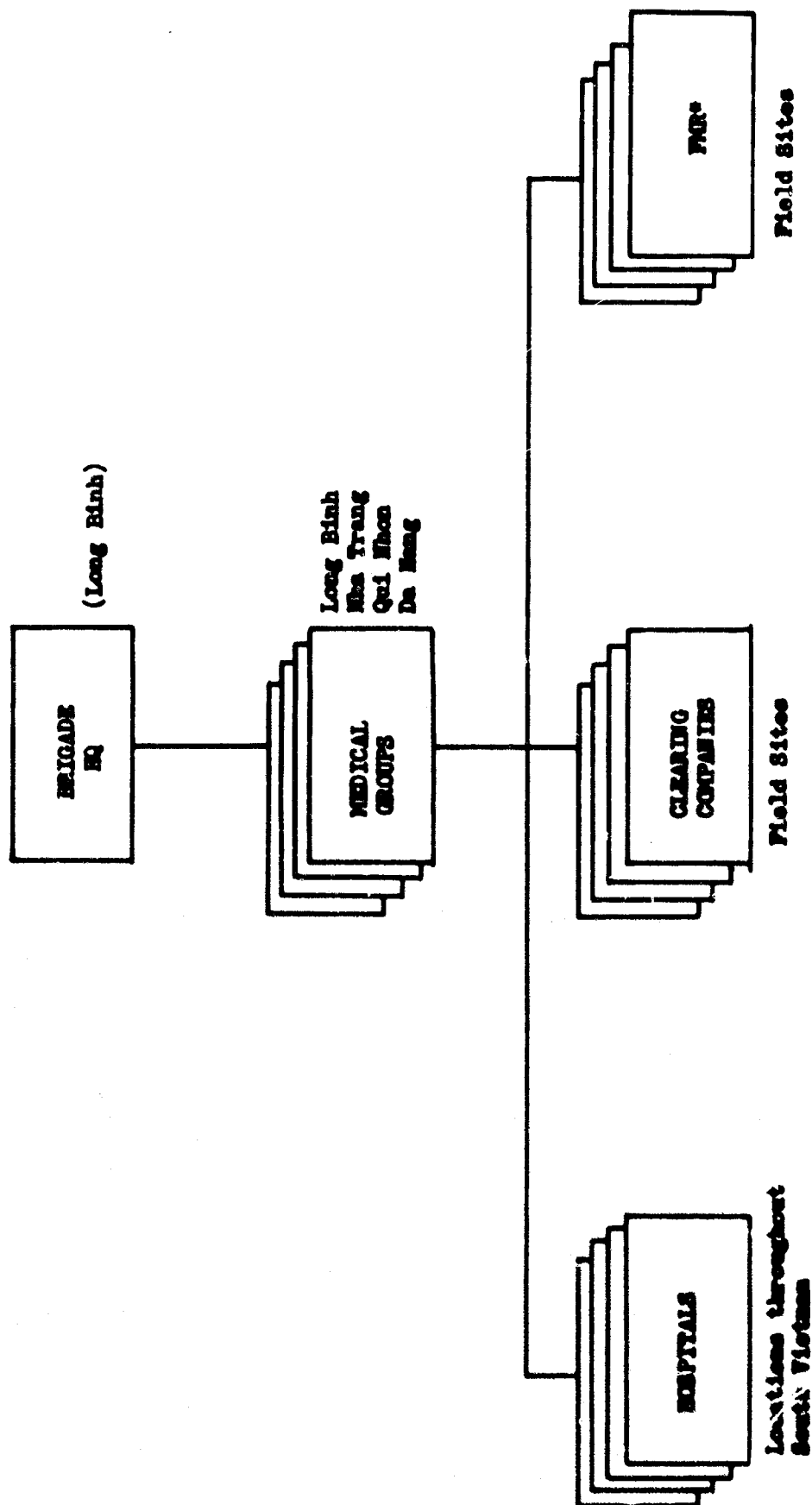
- a. Redesignate 8th Fld Hosp (Nha Trang) and 3d Fld Hosp (Saigon) as Evac Hosp, MTOE 8-581E
- b. Reorganize:
 498th Med Det (RE) as a Team RB, TOE 8-500G
 210th Med Det (MC) as a Team MA, TOE 8-500G
 346th Med Det (MA) as a Team OA, TOE 8-500G
- c. Reduce strength:
 32d Med Depot
 176th Med Det (JB)
 760th Med Det (JB)
- d. Activate two Med Det (RB), TOE 8-500G

Alternatives A, B, D, E

- e. Redesignate and/or reorganize as Evac Hosp, TOE 8-581G:
 95th Evac Hosp
 8th Fld Hosp
- f. Reorganize 498th Med Det (RE) as Team RB, TOE 8-500G and 210th Med Det (MC) as a Team MA, TOE 8-500G
- g. Reduce strength:
 32d Med Depot
 176th Med Det (JB)
 760th Med Det (JB)
- h. Activate two Med Det (RB), TOE 8-500G and one Disp (MC) MTOE, composed of one each teams KA, KH, MC to make a single organization/unit.

48. (SNF) 44th Medical Brigade organizes roll-up teams on or before T-Day.

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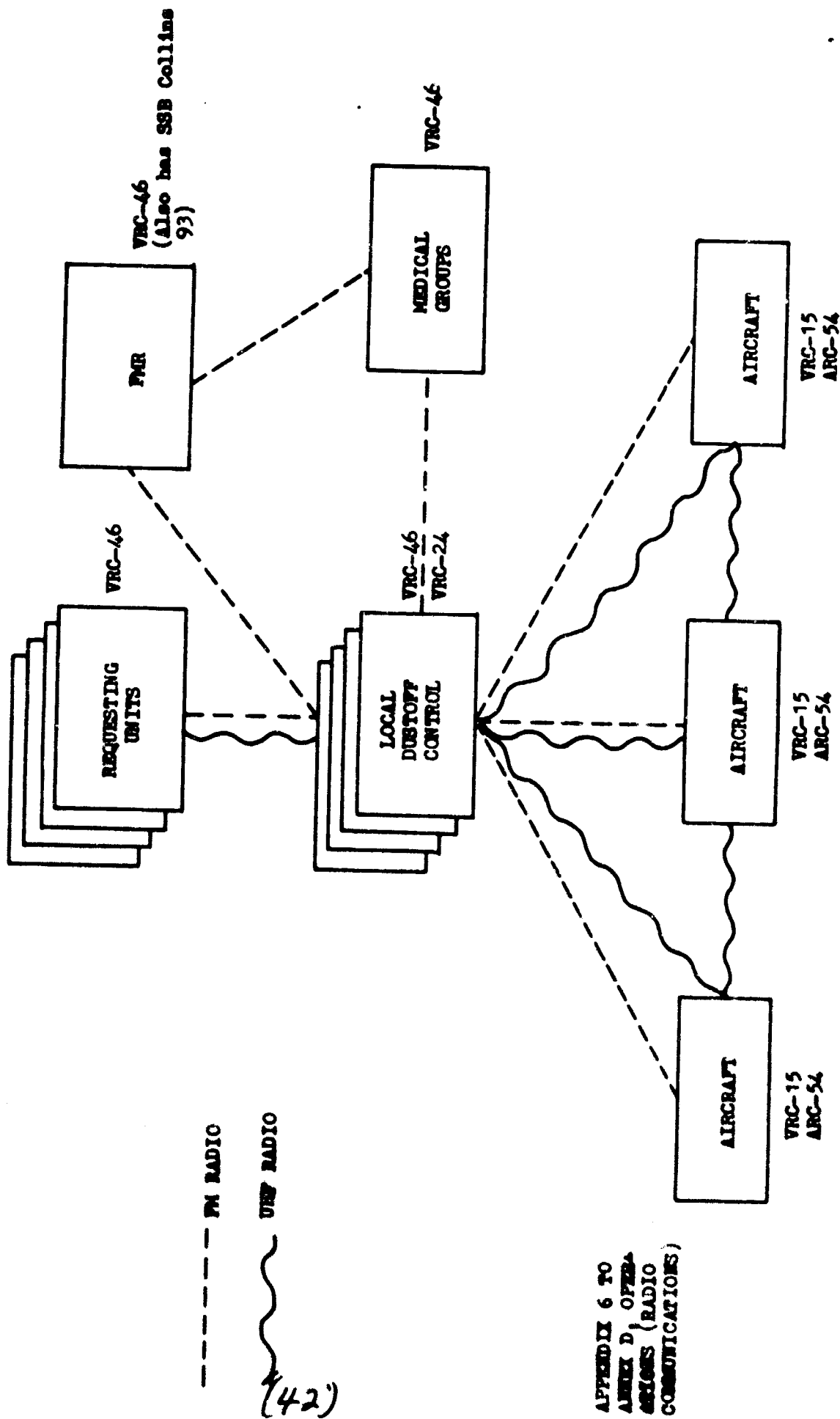


APPENDIX 5 TO AMEXI D, OPERATIONS (RADIO COMMUNICATIONS)

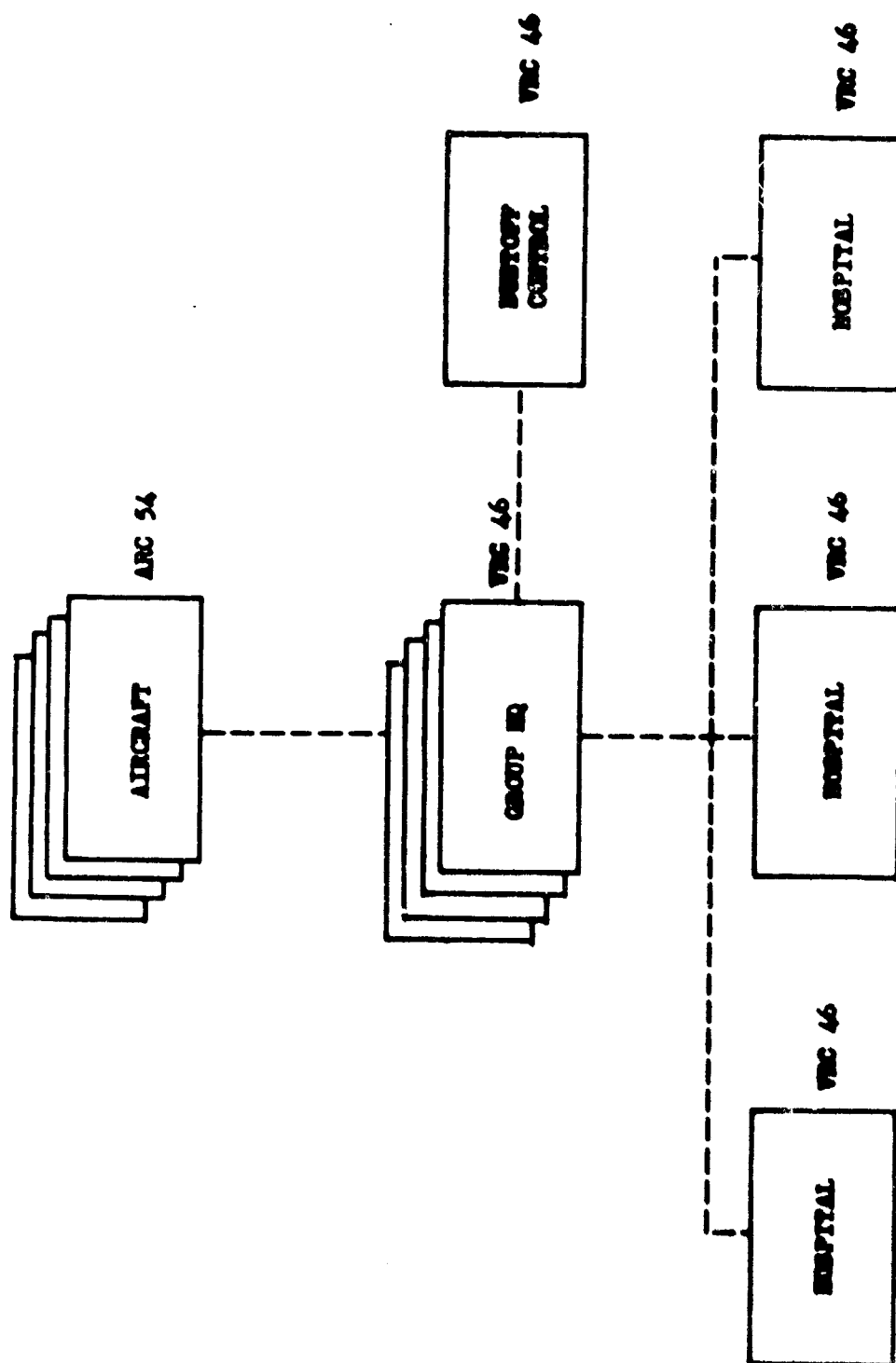
*FMR--Field Medical Regulator

(41)

DUSTOFF (PRIMARY FREQUENCY) AND UHF NETS VRC-24



DUSTOFF FM (ALTERNATE FREQUENCY)



APPENDIX 7 TO ARMS D, OPERATIONS (RADIO COMMUNICATIONS)

AVIATION STATISTICS
1968

	AUG	SEP	OCT	NOV	DEC	JAN	TOTAL
Number of Times Hit by Hostile Fire	33	44	26	15	22	18	158
Number of Hoist Missions (Patients)	91	137	115	129	160	124	756
Number of Times Hit by Hostile Fire	3	3	4	1	1	2	14
Number of Crew Killed	0	3	9	1	2	4	19
Number of Crew Wounded	8	12	7	6	10	5	48
Number of Patients Killed	0	4	7	1	0	4	16
Number of Patients Wounded	1	0	5	0	0	0	6
Number of Aircraft Combat Losses	4	5	4	1	2	1	17
Total Number of Missions Flown	7439	6938	6926	6639	7530	4798	40270
Total Flight Hours	6282	5188	5385	5111	6103	4346	32415
Number of Patients Evacuated:							
US Patients	7181	7108	6125	5457	5836	4784	36491
FMFAP	610	445	362	426	410	316	2569
ARVN	5489	5707	4254	3384	4298	3182	26314
RVN Civilian	3038	2836	3523	3483	3733	2334	18947
Other	597	680	420	528	574	521	3320
TOTAL	16915	16776	14684	13278	14851	15394	91889
Average Number of A/C on Hand	102	102	101	102	112	116	116
Average % A/C Availability	73%	67%	68%	67%	78%		

(44)

APPENDIX 8 TO ANNEX D OPERATIONS (JUST-OFF)

ANNEX E

PROFESSIONAL SERVICES

1. (U) MEDICINE -- a. Malaria -- Treatment for malaria is essentially unchanged. Treatment of primary attack of vivax and falciparum malaria is usually in the form of oral therapy with the standard 1.5 gram of chloroquine (divided dose) and 14 days of 15 mg per day of Primaquine. After being afebrile for 2 days, individuals are returned to duty to complete therapy as an outpatient. The total time lost for the average vivax malaria patient is now only 5 - 8 days; falciparum patients on the average lose 17 - 19 days.

b. Hepatitis -- In general the disease has been relatively mild. All patients with a diagnosis of hepatitis are evacuated to offshore hospitals where convalescence takes an average of 40 or more days.

c. FUO (Fever of Undetermined Origin) -- A continuing study of fevers is being carried out by the 9th Medical Laboratory with the cooperation of all medical services in submitting specimens and clinical data sheets.

d. Dermatology -- The assignment of a dermatologist to each corps tactical zone has resulted in increased proficiency in the management of skin disease. Approximately 30 patients are evacuated monthly for skin disease. The use of prophylactic griseofulvin has been encouraging in the management of skin disease of the foot in the Delta.

e. Renal Unit -- The end of April will mark the 3d anniversary of the Renal Unit in Vietnam. The fostering of increased awareness of clinical situations leading to renal failure and the dissemination of information on management by members of the unit combined with the proficiency of the unit in hemodialysis has been a decided factor in the lowering of mortality in acute renal failure.

f. Melioidosis -- This disorder caused by *Pseudomonas pseudomallei* is seen most frequently in III Corps Tactical Zone (CTZ). Recent studies have indicated that long term tetracycline therapy is the treatment of choice. Mild pulmonary forms are treated and returned to duty. Chronic granulomatous or septicemic forms are evacuated to offshore hospitals. Three or four cases are evacuated each month.

g. Disease of the Heart and Respiratory System -- These occur with the same frequency as in CONUS. Approximately 40 - 50 patients are evacuated each month with uncontrolled asthma and hypertension accounting for the majority of patients.

2. (U) SURGERY -- a. During the period June 1968 through December 1968, 14,709 US military casualties were admitted to US Army operated hospitals in RVN. Over 55% of wounds were caused by fragments from mines, booby-traps,

grenades, rockets etc. Bullet wounds accounted for over 35% of cases admitted to hospitals. Punji stick injuries were very rarely encountered in contrast to previous years. The use of more sophisticated weaponry by hostile forces produced wounds of a more severe nature, and required that 53.8% of injury resulting from hostile action (IRHA) admissions be evacuated out-of-country to PACOM hospitals for further treatment. The mortality rate for IRHA patients during this period was 21.4% and attests to the high calibre of professional care provided in RVN.

b. Location of Wounds — Body areas involved by wounds showed little change from previous reports. Head and neck wounds made up about 12% of the total. Thoracic wounds were present in about 5% of IRHA patients while abdominal wounds have been encountered in about 13% of cases. The extremities, as expected, sustained the highest percentage of injury - 63%. The small bowel is the most commonly injured intraabdominal organ, closely followed by the large bowel. The liver ranks third in frequency of injury. The spleen and kidney are next most often involved. With the high incidence of extremity wounds, it is not surprising that over 1000 vascular injuries have been treated during this period of time. The amputation rate following vascular repair is about 11%.

c. Deaths — (1) Cerebral wounds continue to account for about 40% of IRHA deaths. It would appear that until a helmet is devised which is not only protective, but comfortable, head wounds will continue to produce this high percentage of death.

(2) Wounds producing severe hemorrhage and shock result in another 40% of IRHA mortality. This may well represent those patients with mortal wounds who in other wars never reached the hospital. Almost invariably, patients in this group die within 24 hours after admission. The tremendous effectiveness of the "Dust-off" crews has resulted in many casualties reaching an area of definitive therapy within 30 minutes of wounding. At the present time there is no indication that major improvement can be made in salvaging patients who fall into this category.

(3) Sepsis is the third most common cause of mortality in IRHA patients. About 15% of deaths occur in this group. This appears to be the area where greatest progress can be made. Careful attention to established and proven surgical procedures is an absolute necessity. Certain problems constantly recur, despite repeated emphasis and rehashing of the "whys and wherefores" of treatment. These will again be strongly reiterated in the forthcoming CINCPAC monograph on War Surgery.

(4) Pulmonary complications causing death have decreased markedly during this report period. Early institution of treatment of "shock lung" (tracheal-bronchial toilette, availability of volume respirators, and monitoring of blood gases) has been effective. Including pulmonary embolus and pneumonitis, 4% of deaths have been attributed to pulmonary insufficiency.

(5) Other causes of hospital deaths included burns and coagulation defects.

3. (U) NEUROPSYCHIATRY, NEUROLOGY AND PSYCHOLOGY -- a. Sufficient numbers of well trained professional personnel were assigned to carry out the basic mission. Fully trained psychiatrists were assigned to the combat divisions. Psychiatrists who had not completed a three year residency were assigned to the 44th Medical Brigade under the direct supervision of fully trained psychiatrists.

b. Improvement was seen in the effort to develop decentralized consultation services throughout the country. The centralized treatment programs were significantly improved through the needed support of the hospital commanders.

c. The relationship between command and the mental hygiene units has been uniformly superb. A complete full time mental hygiene team has been detailed by the Commanding Officer of the 935th Medical Detachment (KO) to support the mental health needs of the USARV stockade. This effort has been enthusiastically supported and praised by the correction officer in charge of the stockade.

d. Neurology support has been improved by the assignment of additional neurologists to the 95th Evacuation Hospital. Previously Army neurology referrals in I CTZ were made to Navy Neurologists. Two EEG machines were received and have been placed at the 93d Evacuation and 8th Field Hospitals. This addition will facilitate the diagnostic capability of the neurologists and will eliminate the need for out-of-country evacuations for this service.

4. (U) NURSING SERVICE -- Nursing Service in the Republic of Vietnam continues to provide nursing care in the traditions of the profession. Nursing consultants assigned to the MACV Surgeon's Office, the Chief Nurse of the Ministry of Health-Government of Vietnam, the Nursing Consultant, USAID, the Chief Nurse, Republic of Korea Forces Vietnam, Chief Nurse, Air Force Casualty Staging Facility, and the Chief Nurse USARV/44th Medical Brigade conducted conferences in October, December and January to plan and coordinate the programs of all agencies, reduce duplication of resources, improve nursing care and elevate the nursing profession in Vietnam.

5. (U) DENTAL SERVICE -- a. Organizational Changes: (1) The 650th Medical Detachment (Dental Service) arrived in-country on 27 August 1968. This unit has dental clinics located at Long Binh and Bearcat. The 137th Medical Detachment (Dental Service) relocated its headquarters from Bearcat to Dong Tam during the period 15 to 27 August, to provide area dental support for the 9th Infantry Division.

(2) Dental officers, MOS 3170, assigned to hospitals and dispensaries were attached to the dental service detachments (Teams KJ) located in the geographical area for operational control and guidance from the senior dental

officers. The dental service has shown definite improvement under this concept.

(3) Five mobile teams were organized during this period. The 39th Medical Detachment (Dental Service) developed an air mobile pod dental clinic to support the 4th Infantry Division; 219th Medical Detachment (Dental Service) developed 2 mobile dental clinics, each in the back of a shop van (M109A3 6x6 2½ Ton), to support the Americal Division in the Chu Lai area; the 137th Medical Detachment (Dental Service) developed similar mobile vans to support isolated areas of the 9th Infantry Division and the 199th Infantry Brigade.

b. Dental officer personnel strength during this period: 276.

c. Dental facilities:

(1) During this period 99 dental clinics were operated.

(2) Major construction: (a) Construction of the new 8 chair dental clinic at the Phu Bai airfield was completed and became operational by the 56th Medical Detachment (Dental Service) on 3 November 1968. This clinic is air-conditioned, has Castle wall mounted lights and a well equipped laboratory.

(b) The new air-conditioned 14 chair dental clinic on Long Binh Post for the 650th Medical Detachment (Dental Service) became operational 10 December 1968. A central dental laboratory for the fluid resin technique to support the 38th Medical Detachment (Dental Service), 257th Medical Detachment (Dental Service), 499th Medical Detachment (Dental Service) and 650th Medical Detachment (Dental Service) located in the Long Binh - Bien Hoa area became operational during 1st quarter CY 1969 at the 650th Medical Detachment dental clinic.

(c) The new 3 chair dental clinic at the 3d Field Hospital in Saigon became operational in December 1968.

(d) The Preventive Dentistry facility at the 90th Replacement Battalion is 98% completed and became operational during January 1969.

(e) The new dental clinic being constructed for the 137th Medical Detachment (Dental Service) located at Dong Tam is 80% completed and should be fully operational during 1st quarter CY 1969.

(f) The Preventive Dentistry facility at Cam Ranh Bay became operational on 29 December 1968. This facility can treat a group of 180 personnel in 20 minutes. Approximately 25,000 personnel will receive the fluoride self-treatment each month at this facility when processing in-country for R&R.

d. Preventive Dentistry Programs initiated: (1) The fluoride self-treatment paste was introduced in the USARV Preventive Dentistry Program during the month of August. 157,506 personnel have received this treatment and no adverse reactions were reported as to the patients acceptance of this treatment.

(2) Equipment and supplies for the Intermediate Restorative Material Program were distributed to the dental service detachments during December. Table clinics were conducted on the use of this material in December. The IRM Program will become fully operational 1st quarter CY 1969.

e. Total patient treatments this period: 476,328.

5. (U) VETERINARY SERVICES — a. Improvements in performing surveillance inspections of military subsistence during the last six months was due to improved record keeping procedures by subsistence managers and the implementation of statistical sampling by veterinary inspectors. The sampling enhanced the efficiency of assessing the quality of stored food supplies. As a result, stressed items were identified in sufficient time to permit their use before extensive loss. The quantities of condemned government owned subsistence decreased during this period, which validates the benefits of properly programmed inspections.

b. There has been a decided improvement in the quality of care and treatment given military dogs deployed in Vietnam. Close surveillance of the dogs' health is maintained by the attending veterinarian who conducts periodic examinations to insure that the animals are in a good state of health. A reporting system was established to provide data relative to morbidity and mortality rates of animals on a monthly basis. Weekly ward rounds have been initiated at the Veterinary hospital, which insures that hospital cases are properly evaluated and pertinent laboratory tests are performed, enhancing the quality of professional care given to hospitalized animals.

c. A central control point was established to requisition, store and distribute non-standard veterinary drugs and biologicals. This has significantly reduced the variety and quantity of items stocked in the supply system and has provided a means of maintaining adequate stock levels through normal requesting procedures.

d. A standard dog kennel plan has been designed for use in the construction of dog facilities in Vietnam. The design is based on a modular concept and therefore provides flexibility in selecting a structure that will accommodate the number of dogs assigned to the unit. Thirteen models are available.

e. A monthly publication "Veterinary Newsnote Vietnam" was initiated in October. This newsnote has served a most useful purpose in conveying technical and professional guidance to personnel in remote areas.

7. (U) **DIETARY SERVICES** -- The authorization and assignment of a staff dietitian to the USARV Surgeon's staff with additional staff responsibility to the 44th Medical Brigade improved the quality of food service operations within the command. During the initial months, emphasis was placed on mess hall sanitation and layout, procurement of garrison mess equipment, training of cooks in patient feeding on the wards, training of local Vietnamese personnel, mess management and administration, standard hospital diets, and procurement of supplemental foods and beverages. TOE equipment has been replaced with garrison mess equipment in most Free World Military Assistance Forces' hospitals and in all 44th Medical Brigade units, except for the field ration messes in I CTZ.

ANNEX P

PREVENTIVE MEDICINE

1. (U) **MALARIA** — a. Incidence: Malaria continues to be a most serious disease within USARV, although malaria rates have decreased significantly during 1968. Malaras are now being reported routinely by type (falciparum vs Vivax). The ratio is approximately 60:40 respectively.

INCIDENCE RATE PER/1000 PER YEAR

1966			1967			1968		
Cases	Rate		Cases	Rate		Cases	Rate	
JAN 181	18.0		616	29.6		579	20.6	
FEB 130	14.6		420	23.7		377	15.0	
MAR 280	27.9		471	21.8		328	11.3	
APR 658	52.5		615	26.1		511	17.5	
MAY 448	32.7		763	30.3		611	22.4	
JUN 688	52.3		873	36.0		801	26.8	
JUL 569	40.8		891	33.9		935	30.8	
AUG 280	19.4		660	24.6		920	30.4	
SEP 923	64.2		754	29.1		887	30.4	
OCT 707	43.6		1162	43.8		938	31.5	
NOV 764	50.2		1072	40.5		882	28.1	
DEC 1054	59.4		842	30.7		807	26.6	

b. Prevention. (1) Malaria chemoprophylaxis: Commanders who are interested in prevention of malaria have low rates in their units. Malaria chemoprophylaxis remains the primary program of malaria prevention in Vietnam. Individuals assuming the highest risk are the combat infantrymen, particularly those in the central highlands and along the Cambodian border. At the present time, all personnel in USARV take a weekly tablet of chloroquine-primaquine (C-P) tablet (combined 0.3 gm chloroquine base with 45 mgm primaquine base). In addition to this, the combat forces in I and II CTI are required to take 25 mgm of dapsone daily. Wherever falciparum malaria occurs or resistant strains of vivax malaria are noted, the command surgeon

may recommend to the appropriate commander that dapsone administration be started.

(2) Unit protective measures: Field sanitation team training has been given priority emphasis. All units of company size must have an appointed team of 1 NCO and 2 additional enlisted men. These units are trained under the auspices of battalion and/or squadron surgeons by 20th and 172d Preventive Medicine Units personnel. Field sanitation teams are instructed in the use of insecticides, sprayers, administration of malaria chemoprophylaxis and basic sanitation.

(3) In general, aerial spraying during 1967 was reported to be relatively ineffective in the control of malaria in Vietnam. This was due in part to the fact that the infantrymen contract the disease in relatively inaccessible jungles far from base camps. In 1968 only one Air Force C-123 aircraft and one approved helicopter (UH 1B/D) spray rig were made available for control of mosquitoes. Poor weather, hostile and friendly artillery fire and maintenance problems have created problems in both aerial and ground spray operations. Nightly fogging with insecticides and residual spraying of the interior of quarters are effective additional measures employed during 1968.

(4) Twelve helicopter spray units have been requisitioned for use by the preventive medicine units for control of mosquito larva and adults. The request has been recognized by USARPAC and is awaiting DA approval. The requisition is being processed to USAMECOM, St Louis, Missouri for procurement. Sprayers are reported to arrive in RVN in April-May 1969 when the next malaria season begins. The helicopter units will be assigned for use over areas 20 square km or less, while the C-123 is to cover areas of more than 30 square km. The helicopter spray equipment is best used around night defensive positions, landing zones, and various other outposts where malaria rates are highest.

(5) The C-123 aerial program was evaluated in November 1968. These field tests revealed that effective control of mosquitoes can be obtained for up to 7-10 days after completion of each spray. Under optimum conditions both adults and larval mosquitoes are controlled in cleared areas as well as forested areas. A test area (Buon Bloch) was selected which would present the varied terrain features of Vietnam, from cleared areas to forested jungle terrain. The missions were flown at 0645-0720 under optimum weather conditions of clear skies, wind of less than 5 mph, and a ground temperature of around 70 degrees F. Flight level was maintained at 150 feet above ground at a speed of 130 knots. Equipment was operated at 60 psi to deliver 0.5 pounds of actual toxicant per acre. Each spray pass at this elevation covered a 500 foot swath. Oil sensitive dye cards and cans containing live mosquito larvae were set out in open areas and in areas of forest with thick undergrowth. Man-biting collections were made in the area prior to and after the mission. An estimate of the larval population in ground pools in the spray area was made on the day before

the mission. Results indicate that *Anopheles Maculatus* is the primary vector of malaria. This species comprised 74.9% of the man-biting species of *Anopheles* and in August and September of 1968, four positive *Anopheles Maculatus* stomachs were found with oocysts. Earlier investigations conducted in 1967 proved the species to have oocysts of the stomach and sporozoites within the salivary glands.

(6) This same low volume concept is a very effective means for controlling not only adult and larval *Anophelines* but also other mosquitoes, both pestiferous and disease-producing of the genus *Culex* and *Aedes*. It is difficult to prove, but it is virtually certain that mosquito control directed against the *Anopheline* vectors of malaria, also reduced the potential of mosquito borne disease of viral and nematode etiology (Japanese V-Encephalitis and Filariasis). Only sporadic cases of these two diseases occurred within USARV troops throughout Vietnam.

(7) Failure to take the chloroquine-primaquine tablet remains one of the major problems in the control program. What has been needed in the past was a method to objectively evaluate the effectiveness of a unit's chemoprophylactic program. The Wilson-Edeson test for urinary chloroquine introduced by the 172d PMU has proven a useful tool in measuring the success or failure to take the chloroquine-primaquine tablet and identifies for the commander those units which need additional effort. The test was first introduced in October and since then most of the divisions and brigade size units have adopted it. However, the problem remains one of strict command emphasis at each level down to the squad leader who is responsible for making sure that each man takes his pill.

2. (U) INFECTIOUS HEPATITIS — a. Incidence: The hepatitis admission rate by combat and other units from December 1967 to December 1968 is given in the following chart.

HEPATITIS RATES/1000/YEAR BY COMBAT
AND OTHER UNITS, USARV DEC 67 - DEC 1968

<u>MONTH</u>	<u>COMBAT UNITS</u>	<u>OTHER ARMY</u>	<u>USARV</u>
DEC 67	7.9	4.3	5.7
JAN 68	7.2	3.3	4.9
FEB	4.5	3.3	3.8
MAR	6.9	4.5	5.5
APR	5.6	4.6	5.0
MAY	9.2	5.3	6.9
JUN	5.1	5.8	5.4
JUL	9.1	7.8	8.3

AUG	11.4	6.0	8.2
SEP	6.3	5.7	6.9
OCT	4.7	7.6	4.8
NOV	4.5	4.8	4.6
DEC	4.6	3.9	4.2

Unlike malaria the proportion of total cases of hepatitis is related to the proportion of total strength of combat units and support troops in USARV. Combat units have a slightly higher percentage of total cases in relation to their strength.

	COMBAT UNITS	OTHER ARMY
% of total hepatitis cases	49.6	50.1
% of USARV strength	45.7	54.3

b. Prevention: Although the number of cases of hepatitis is relatively low compared to malaria, the long period of hospitalization and convalescence makes it an important contributor to man-days lost and non-effectiveness in RVN. The great majority of cases reported have been traced to eating and drinking from other than approved mess facilities, viz, the local economy. Education of the troops to the danger of eating contaminated food, water and ice from the local economy must be stressed. Gamma globulin, at the discretion of the command or unit surgeon, has been administered in certain units where a food handler or similar individual has been identified with infectious hepatitis.

3. (U) DIARRHEAL DISEASE -- a. Incidence: The USARV diarrheal disease rate from December 1967 to December 1968 is given in the following chart.

USARV DIARRHEAL DISEASE RATE/1000/ANNUUM
DEC 1967 to DEC 1968

<u>MONTH</u>	<u>RATE/1000/ANNUUM</u>
DEC 67	40.3
JAN 68	34.4
FEB	30.6
MAR	49.8
APR	52.6

MAY	67.5
JUN	57.7
JUL	49.7
AUG	49.9
SEP	33.1
OCT	32.7
NOV	31.7
DEC	29.5

As the chart indicates, the diarrheal rates have been gradually decreasing since August. Some of this downward trend is undoubtedly due to seasonal variation. However, part may be due to a general improvement in sanitation.

b. Prevention: Most of the cases are sporadic and isolated, producing little morbidity. The larger outbreaks have usually been traced to Shigella or Staphylococcal food poisoning. Most of these incidents are due to a failure to enforce strict continuous food service sanitary standards, failure to effectively motivate troops to the danger of eating or drinking on the local economy, failure to properly use the iodine tablets for water purification, and in rare instances failure to properly chlorinate at unit water points.

4. (U) FEVERS OF UNDETERMINED ETIOLOGY (FUO) — a. Incidence: The USARV FUO rates/1000/annum are given in the following chart for Jan - Dec 68. The FUO rate exhibits a seasonal incidence with the highest rates in August and September and the lowest rates during January, February and March.

FUO/1000/YEAR, UNCORRECTED,
USARV JAN - DEC 1968

<u>MONTH</u>	<u>FUO</u>
JAN	53.5
FEB	49.2
MAR	42.7
APR	51.0
MAY	58.7
JUN	59.1

JUL	56.2
AUG	71.5
SEP	73.8
OCT	54.9
NOV	59.3
DEC	52.1

It is difficult to draw any conclusions from these rates because of the reporting method. Line 118 of the Morbidity Report, DA Form 8-268, includes not only fevers of unknown etiology but other ill-defined conditions which include headache, backache, abdominal pain and a variety of other signs and symptoms of questionable etiology. Taken as a group, however, this category of illness does represent a major contribution to morbidity in RVN. Past studies based on serological titers of acute and convalescent sera on patients admitted to the hospital with FUO have indicated that common causes are most likely malaria, scrub typhus, leptospirosis, dengue, chikungunya and other Group A and B arboviruses.

b. Prevention: Control measures aimed at reducing the number of potential vectors will be effective in reducing FUO due to malaria, dengue, chikungunya and other Group A and B arboviruses. These measures have already been discussed under malaria. Proper use of insecticides or proper treatment of terrain prior to setting up camp sites will help reduce the incidence. Preventing rodent contamination of swimming pools and bathing facilities along with education of individuals to the danger of bathing in natural streams and ground pools will also reduce the cases due to leptospirosis.

5. (U) **ENEREAL DISEASE** -- a. Incidence: The monthly venereal disease rate has varied from a high of 250/1000/annum in January 1968 to 159.3/1000/annum for December 1968 with a low of 142.2/1000/annum in March 1968. Gonorrhea accounts for about 90% of the total rate and syphilis about 0.75% with other VD accounting for the remainder. Other VD includes primarily chancroid and lymphogranuloma venereum.

b. Prevention and control: The VD control program in USARV emphasizes troop education, availability and use of prophylactics, enforcement of off limits areas, prompt early diagnosis and treatment of infected personnel.

6. (U) **DISEASES OF SKIN AND CELLULAR TISSUE** -- a. Incidence: The monthly rate for skin diseases varies from 14.9/1000/annum to 30.1/1000/annum. However, the rate in certain units is much higher. The 9th Infantry Division reports a true incidence rate of 1022.5/1000/annum for December 1968. Skin disease is easily the greatest single cause of non-effectiveness in this division's troops in the Delta.

b. Prevention: Factors which have been found to be effective are limiting to 48 hours duration those combat operations in wet areas, routine unit foot inspections, adequate provision of dry socks, and encouraging the wear of shorts and shower shoes in base camp areas.

7. (U) INSECT AND RODENT CONTROL -- Insect and rodent surveys were continued throughout the Republic of Vietnam during 1968. By the end of 1968, preventive medicine personnel were situated in direct support of major combat units and area commands. Preventive medicine activities were covered on an area basis from the following locations: Hue-Phu Bai, Chu Lai, Pleiku, An Khe, Qui Nhon, Cam Ranh, Lai Khe, Phu Loi, Saigon, Bien Hoa, Tay Ninh, Dong Tam, Vung Tau, Soc Trang, Tuy Hoa, Cu Chi, Long Binh, and Can Tho. As soon as data on medically important arthropods are available from laboratories of the 20th and 172d Preventive Medicine Units, the information is furnished to command and area surgeons. Whenever the indices indicate specific areas of concern, the surgeon may increase aerial spray programs, ground control activities, or unit and personal protective measures. Flea pools, splenic examinations and serologies are conducted to determine focal centers for plague. Isolation studies are carried on by the Institutes of Pasteur, either at Saigon or Nha Trang.

8. (U) WATER SUPPLY -- a. Water supply surveillance by preventive medicine personnel, area and unit surgeons has been an absolute necessity to assure an adequate supply of potable water. The magnitude of this situation is shown by the number of fixed points providing potable water (over 160). This figure excludes those water points operated in the field by engineer troops organic to or in direct support of combat units.

b. The sources of water for about 40 percent of the fixed water points are surface waters or shallow wells. Failure to properly treat and disinfect these sources results in outbreaks of waterborne disease including gastroenteritis, dysentery, and hepatitis. Sixty percent of the fixed water sources are deep wells which require minimal treatment. The USARV program to provide additional deep wells (to total over 240) is nearing completion. The deep wells will replace some of the surface water sources and reduce the potential for contamination. However, all potable water, regardless of the source, must have a free available chlorine residual of 5 parts per million (ppm) at the plant after 30 minutes contact time. Most of the potable water produced is delivered in tank trucks, trailers, and other containers to the consuming unit. Incidents have been reported in which nonpotable water was procured, delivered, and consumed. When such incidents involve large numbers of troops, measures are taken to prevent hepatitis by administering prophylactic gamma globulin to all personnel who consumed the water. Because of the risk of contamination during delivery and transfer of water, a chlorine residual of 2 ppm must be found at the point of consumption. The consuming organization must test delivered water daily using the Orthotolidine testing kit, (PSN 6850-979-9489). Testing delivered water is one means of assuring a potable supply. In January, the supply of expendable test kits was exhausted and action was

has established a requirement objective of 100 ml per man for USARP. A small number of soldiers in the field must rely on available sources of nonpotable water. Adequate quantities of individual latrine water purification tablets are provided for disinfection. Few cases have been reported where soldiers fail to utilize their iodine tablets properly. The monitoring of potable water production and supply will continue to be a major effort.

9. (U) WASTE DISPOSAL -- a. Human wastes are disposed of by conventional field devices and to a limited extent by waterborne sewage systems. Oxidation ponds or sewage lagoons as well as septic-tank subsurface disposal systems are used for final disposal of waterborne sewage. Urine soakage pits with or without urinals are used by most small units. Burn-out latrines are used by units without waterborne sewage disposal systems. This type latrine consists of a flyproof structure or cover and uses the bottom third of a 55-gallon drum for a container. Eight containers will serve 100 men and cost approximately \$2.24 per day for fuel oil for incineration. Notwithstanding the high cost of operation, the burn-out latrine has proven to be more effective than other forms of ground disposal in preventing contamination.

b. Refuse, including garbage and trash, is disposed of by burial. Sanitary fills are operated at large base camps. Unless the disposal site is secured from native scavengers and the refuse properly covered, using mechanical equipment, the fill becomes an open dump for rodent and fly breeding. Disposal areas outside of secured compounds or in places with a high water table continue to present a problem. Liquid wastes from food service activities have been a problem in areas where the water table is high or the ground does not provide good percolation. The presence of grease in kitchen waste water has interfered with ground disposal. Grease traps in some instances are not very effective due to poor design, lack of maintenance, and emulsification by detergents.

c. Infectious wastes generated by hospitals and other medical facilities are generally disposed of by special packaging and burial. Several of the larger hospitals have acquired and are operating high-temperature incinerators for infectious waste and anatomical parts disposal. It is considered highly desirable for all fixed medical treatment facilities that generate this kind of waste to have incinerators for disposal.

10 (U) ICE SANITATION -- There is a great demand for ice in RVN for cooling beverages. Consumption of nonpotable ice from unapproved sources, mostly native plants, has been the presumptive cause of many sporadic cases of waterborne diarrhea and other disease. Approved ice plants have had to be closely monitored to assure basic sanitary compliance. Army ice plants are primarily operated by third-country nationals who must be carefully supervised. Civilian ice plants, which have been approved for ice procurement, batch chlorinate only that part of their total production which is for US Army customers. Deliveries from civilian vendors must be constantly checked and rechecked to assure its origin from the Army production side of the plant. Potable ice produced at an approved plant is often contaminated

during delivery and in subsequent handling at its destination. Automatic ice-making machines, in limited numbers, at some clubs and messes have reduced this problem to a degree; however, as long as the soldier is to be provided bulk ice, considerable effort will continue to be needed to safeguard its purity.

11. (U) FOOD SERVICE SANITATION -- The mess kit has practically disappeared from USARV. Troops provided with the A ration use plastic trays, paper plates, or in rare cases, chinaware. The individual combat meal (C ration) is usually consumed with utensils provided with the ration. The problem of sanitizing the individual mess kit has also disappeared along with the kit. Large quantities of fresh produce grown in RVN are provided with the A ration; these items have been shown to be contaminated and must be carefully cleaned and disinfected when eaten uncooked. Food service disinfectant (6840-270-8172) which is intended specifically for treating fresh produce, has been in very short supply throughout 1968. Action to increase the requisitioning objective from 120,000 to 500,000 pouches per month is expected to be completed early in 1969.

12. (U) PREVENTIVE MEDICINE PERSONNEL -- USARV has submitted to DA, an MTOE for the combat divisions which adds one military environmental sanitarian (MOS 3370) and four enlisted preventive medicine specialists (MOS 91S). Technical equipment recommended in the MTOE included chlorine comparators, bacteriological water testing kits, medical entomological surveillance and control equipment and other appropriate items. Between 28 November 1968 and 13 January 1969, five sanitarians and two sanitary engineers were assigned to USARV divisions. These personnel were acquired from the Office of The Surgeon General through type A personnel allocation. The enlisted spaces will not be recognized and filled until the MTOE's are approved by Department of the Army. The addition of the commissioned personnel greatly reinforces the division's ability to cope with preventable diseases and to monitor the use and to improve the effectiveness of unit field sanitation teams which are the mainstay of first echelon preventive medicine services.

ANNEX G

MEDICAL MATERIEL

1. (U) GENERAL -- a. USARV has the primary responsibility for medical supply support to all US Army Forces in RVN. In addition, medical supply support is provided to the US Navy and Free World Military Assistance Forces (FWMAF) located in the II, III, and IV Corps Tactical Zones (CTZ). The medical supply support mission is accomplished by the 32d Medical Depot located at Cam Ranh Bay and four advance depots located at Long Binh, Qui Nhon, Chu Lai, and Phu Bai. Approximately \$30 million of medical materiel is issued annually in RVN to support the medical service mission.

b. Although no major offensives were conducted during this reporting period, the demands for medical materiel continued high. The expanded reconnaissance in force operations performed by all combat elements and the increased command emphasis on the MEDCAP pacification programs contributed significantly to the continued high demands for medical materiel. Despite the activity, the supply performance of the 32d Medical Depot remained relatively constant during the period for standard items, but dropped significantly for nonstandard items. This decrease is attributed to the difficulties experienced in obtaining nonstandard items from CONUS. The following is the supply performance for the five medical depot activities during this period:

<u>MONTH</u>	<u>SUPPLY PERFORMANCE (percentage of fill)</u>	
	Standard	Nonstandard
August	83%	71%
September	84%	78%
October	84%	69%
November	84%	66%
December	82%	60%

2. (U) SIGNIFICANT ACTIVITIES -- a. In October, with the assignment of a medical maintenance officer, a command medical maintenance program was initiated. In order to determine the medical maintenance problems existing in the command and to discuss present maintenance policies and procedures presently in effect, a medical maintenance conference was held at Cam Ranh Bay in November with representatives of the USARV Surgeon's Office, 44th Medical Brigade, and the 32d Medical Depot. This conference assisted the command in developing a more effective and comprehensive medical maintenance program. To initiate the program, the first medical maintenance

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bulletin was published in December. The bulletin will be published on a monthly basis and will provide medical units with specific maintenance procedures for selected items of medical equipment. A command medical maintenance regulation is being readied for publication, which will establish command maintenance policies and assist units in establishing their medical maintenance programs.

b. To evaluate the effectiveness and adequacy of the medical supply support provided US Army medical units in RVN, frequent liaison visits were made. In November and December, liaison visits were made to combat divisions. The medical supply activities of the organizations were found to be operating excellently. The supply performance (percentage of fill) of these medical supply activities to their customers ranged from 90 to 95%. These liaison visits also provided a means for disseminating current command policies and procedures in the management of medical materiel and assisted the supply officers in resolving medical supply problems.

c. In an effort to improve the medical materiel management, increased emphasis has been placed on obtaining additional ADP equipment for the medical depot activities. In addition to the two NCR 500 computer systems presently installed at Long Binh and Cam Ranh Bay, an NCR 500 computer was placed in the 2d Advance Depot, Qui Nhon to mechanize the stock control activity. Two additional NCR 500 computer systems for the 507th Medical Detachment (FC), Chu Lai and the 4th Advance Depot (PROV), Phu Bai, are scheduled for receipt in March 1969. The installation of mechanized equipment in all medical depot activities will assist immeasurably in the establishment of a centralized inventory management system for medical materiel in RVN. A Data Automation Requirement (DAR) to completely automate medical materiel management in RVN was submitted in October 1968. The DAR is pending DA approval.

d. As an interim measure to expedite the centralized inventory management of medical materiel in RVN, a computer program has been developed to produce a consolidated stock status report of medical materiel within the medical depot activities in RVN. This report, which will be published quarterly, will assist in the leveling of stocks between the depots, enable redistribution of assets and provide a means of identification of excesses within the command. The computer program is presently being tested on a computer system of another government agency. Input data is being collected from all five medical depot activities and the first consolidated stock status report will be released by 15 February 1969.

e. In an effort to control the issue of medical supplies to authorized medical and nonmedical units, an intensified post editing program of medical supply issues to major customers has been initiated. Monthly, an EAM listing of issues made to selected customers are screened to identify items being requested in excessive quantities and items being requested that are beyond the medical treatment capability of the selected activity.

The results of this screening are brought to the appropriate commander's attention for necessary command action. Through the use of this post editing program, the following benefits will be gained: reduction of excessive quantities of supplies being requested; closer command supervision of the issue of sensitive medical items; preclude the issue of medical supplies to unauthorized agencies.

f. The optical fabrication capability in RVN was enhanced during this report period with the activation of the seven combat division optical sections. With the assignment of optometrists and opticians, optical equipment was issued to the combat divisions in September, and the optical sections became operational in late October 1968. With the exception of the 9th Infantry Division, the division optical sections were fabricating 200 to 300 single vision spectacles per month. Pending completion of their optical facility, the 9th Infantry Division anticipates fabricating spectacles in January 1969. The optical facilities of the 32d Medical Depot were also expanded in September and moved from Nha Trang to Cam Ranh Bay. Equipment was installed to provide them the capability of fabricating multifocal spectacles. This capability will significantly reduce the number of prescriptions presently being forwarded to Okinawa. The initiation of the multifocal fabrication was delayed due to lack of air-conditioning for the optical laboratory facility. Work orders have been approved and completion of this project is anticipated by February 1969.

g. With a reduction in the permissive overstockage level, increased command emphasis has been placed on the identification and disposition of medical excesses. In an effort to reduce the amount of excesses retrograded to Okinawa, a program was initiated to transfer medical excesses to RVNAP and USAID medical depots to satisfy their requirements. Concurrence for this procedure was received from USARPAC and all transfers are being managed in accordance with USARPAC's instructions. To date \$146,349.00 of excesses have been transferred to RVNAP and \$2,008.00 to USAID.

h. In spite of continued maintenance problems with Utility Elements, the four MUST surgical hospitals (i.e., 3d Surg, 18th Surg, 22d Surg and the 45th Surg) continued to perform their mission without interruption during this report period. In November, an additional MUST hospital assemblage was requisitioned from CONUS for the 2d Surgical Hospital to be located at Lai Khe. The MUST equipment was received in December and immediately issued to the hospital, which became operational on 10 January 1969. Obtaining vital repair parts for the MUST Utility Element continued to be a major problem in the management of MUST hospitals. The inability of CONUS supply sources to provide the necessary repair parts resulted in approximately 27% of the command's Utility Elements deadlined. To intensify the management of the MUST repair parts in RVN, an officer was assigned in December to the MUST Maintenance Section, 32d Medical Depot, to supervise the operation of the supply account. In January 1969, an improvement was experienced in the receipt of critical repair parts and the receipt of improved status indicates that CONUS support will improve.

Constant communication with MECOM and other NICPs is being maintained by this command to keep them apprised of the essentiality of MUST repair parts requirements.

1. In January 1969, a command medical supply and maintenance conference was held at Cam Ranh Bay. Sixty-one medical supply officers representing the seven combat divisions, separate combat brigades, the cavalry regiment and medical units of the 44th Medical Brigade attended the conference. The major objectives of the conference were to apprise the medical supply officers of current command policies and procedures in the management of medical materiel in RVN, to provide a means of resolving medical supply and maintenance problems and to assist the medical supply officers in developing effective programs to improve the medical supply system in the command. Through this conference a vast amount of information on medical materiel management was disseminated, and the supply officers were able to receive command guidance to effectively improve the management of their supply activities. The success of this conference confirms the need for additional meetings of this nature in the future. Plans are being made to hold similar meetings at each of the advance depots within RVN.

3. (U) SUMMARY — The Army medical supply system continues to function effectively in satisfying demands of the command for medical supplies and equipment on a timely basis. The system has also been responsive to new hospital equipment requirements based on a program of upgrading medical equipment to keep the command hospitals abreast with modern medical technology. Significant progress is being made by the USARV Surgeon's Office, the 44th Medical Brigade and the 32d Medical Depot towards improving the medical supply support performance in RVN, and plans are being developed for additional meaningful improvements in the months to come.

ANNEX H

MEDICAL RECORDS & STATISTICS

1. (U) The problem of inadequately trained medical records and reports personnel has been never ending. The mal-assignment of MOS 71G (school trained medical records clerk) personnel has contributed to this problem area. In addition, experienced 71G personnel have frequently been found to be deficient in the medical records and reports area. This is due to the fact that these functions are handled by civilians in most CONUS hospitals and military personnel are not trained in either medical records or statistical reports. Increased guidance from this office and medical records and reports classes have added in solving this problem, but the rapid turnover of personnel in Vietnam has kept it constantly with us.
2. (U) The Medical Records and Reports Orientation Course was begun in mid-1968. There is a 2½ day program for those personnel who are assigned to non-hospital units and a 4 day program for hospital personnel. Classes were held in Long Binh, Chu Lai, Lai Khe, Nha Trang, Cam Ranh, Phu Bai, Qui Nhon, Dong Tam, and Cu Chi with total attendance of 248 students.
3. (U) Testing and evaluation of mechanized imprinting equipment for use in hospital admissions offices and wards was initiated and completed during CY 1968. Equipment manufactured by the Addressograph Corporation was procured for and tested by the 93d Evacuation Hospital. Pitney-Bowes mechanized imprinting equipment was provided to the 24th Evacuation Hospital for use-testing. Final evaluation concluded that mechanized imprinting equipment was both feasible and desirable for use in RVN. The most enthusiastic response came from the nurses, as time saved in filling out identification data on forms, lab slips, etc., could be devoted to patient care. Accordingly, additional hand (ward type) im printers were recommended. The equipment manufactured by Addressograph was favored over that of Pitney-Bowes because of the availability of maintenance service in-country, reduced cost, and greater versatility. A full report on this subject was completed and forwarded through channels to the Medical Statistics Agency, OTSG.
4. (U) Close coordination has been maintained between the 44th Medical Brigade and the Medical Records and Statistics Division of the USARV Surgeon's Office. During the third quarter of CY 1968, the collection of information for the nightly Bed Status Report was consolidated. Although the procedure did not eliminate the requirement for personnel to work a night shift it greatly aided the reporting units. That data required by both the brigade and the Surgeon's Office has only to be transmitted one time, thus saving time, reducing chances for error, and maintaining better communications discipline.

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ANNEX I
MEDICAL STATISTICAL DATA

TOTAL ADMISSIONS-ALL FACILITIES

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
ALL CAUSES												
1966	1,504	5693	6133	7747	8300	9067	7648	8991	8561	10413	10979	11427
1967	11200	11240	13070	13102	15673	14673	14868	14181	14764	16300	15879	15392
1968	19930	16953	17600	19441	21178	17191	17545	20793	18973	17574	17736	18262
1969												
DISEASE												
1966	3134	3367	3957	5367	5785	6586	5929	6582	6305	7866	7947	8453
1967	7488	6898	8184	8939	10270	10220	10536	10020	10270	11515	10084	10077
1968	8792	6839	9021	9834	11087	10960	11676	12389	11970	11927	11112	11650
1969												
MAL												
1966	856	798	1003	1243	1115	1074	965	1239	1289	1597	1655	1808
1967	1855	1706	2108	1966	2260	2141	2161	2104	2245	2444	2423	2379
1968	2319	2125	2773	2882	2663	2400	2570	2727	2440	2584	2583	2816
1969												
INHA												
1966	514	1528	1173	1137	1400	1407	754	1170	967	950	1377	1166
1967	1657	2636	2778	2197	3143	2312	2171	2057	2249	2341	3370	2936
1968	4819	7989	5806	6725	7828	3831	3299	5677	4563	3063	4041	3796
1969												

Source: Morbidity Report (Dt Form 8-268)

TOTAL ARMY ADMISSIONS-ALL FACILITIES

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
ALL CAUSES												
1966	4164	5121	5794	7267	7790	8551	7221	8361	8060	9617	10201	10598
1967	10215	10248	11895	11820	14155	13283	13357	12529	13219	14720	14065	13393
1968	13656	13305	15186	16768	17963	14288	14840	17244	15724	14546	14098	14594
1969												
DISEASE												
1966	2924	3210	3752	5037	5443	6235	5708	6163	5968	7431	7500	8023
1967	7025	6467	7676	8368	9681	9600	9935	9273	9713	10843	9363	9470
1968	8217	6394	8442	8989	10298	10002	10622	11238	10954	10597	9735	10311
1969												
INHA												
1966	756	735	910	1132	1005	955	845	1106	1179	1348	1422	1515
1967	1531	1442	1734	1598	1739	1676	1600	1600	1766	1991	1960	1854
1968	1874	1598	2247	2354	2187	1943	2014	2155	1944	2003	1915	2153
1969												
INHA												
1966	484	1476	1132	1098	1342	1362	680	1092	913	838	1279	1060
1967	1659	2339	2485	1854	2735	2007	1822	1656	1740	1886	2742	2069
1968	3565	5313	4497	5425	5478	2343	2204	3851	2826	1946	2448	2130
1969												

Source: Morbidity Report (DA Form 2-268)

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**SOURCE OF ADMISSION TO US ARMY HOSPITALS
ALL PATIENTS**

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
TOTAL ADMISSIONS												
1966	3363	3353	3534	5096	5176	5935	6138	6427	6967	7653	8182	8890
1967	8180	8423	9733	9962	11526	10944	10939	10221	10248	11383	11899	10236
1968	11631	11526	11884	14147	17626	13845	13982	15569	14808	14468	14254	14006
1969												
DIRECT ADMISSIONS												
1966	3008	2796	3320	4365	4813	5037	4950	5171	5186	5709	6086	6503
1967	6315	6628	7550	7664	8772	8528	8331	7992	8013	8486	8872	8263
1968	8764	8776	8363	9455	12467	9886	9970	11316	11005	10854	10964	10976
1969												
TRANSFER ADMISSIONS												
1966	375	557	214	731	363	898	1188	1256	1761	1944	2096	2387
1967	1865	1795	2183	2298	2754	2416	2608	2229	2235	2897	3027	1973
1968	2867	2750	3521	4692	5159	3959	4012	4253	3803	3614	3290	3030
1969												

Source: Beds and Patients Report (DA Form 2789)

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DIRECT ADMISSION TO US ARMY HOSPITALS BY CAUSE
ALL PATIENTS

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
DISEASE												
1967	4119	4075	4387	4963	5390	5665	5552	4248	5155	5581	4985	4748
1968	4125	2886	3973	4508	5401	5349	5786	5897	5754	6354	5845	5910
WII												
1967	778	801	999	880	1039	972	1133	2269	1152	1191	1216	1188
1968	1174	1189	933	1435	1416	1624	1883	1813	2001	2066	2127	2189
IRHA												
1967	1388	1752	2204	1821	2343	1891	1646	1475	1706	1714	2671	2327
1968	3465	4701	3457	3512	5650	2913	2301	3606	3250	2434	2992	2877

Source: All Patients & IRHA Beds & Patient Report (DA Form 2789)

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ARMY DIRECT ADMISSIONS TO US ARMY HOSPITALS BY CAUSE

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
TOTAL												
1968	6902	6318	6640	7481	9821	7582	7631	8572	8130	8135	7761	7842
1969												
DISEASE												
1968	3086	2405	2978	3562	4374	4541	4888	4978	4914	5161	4599	4704
1969												
NBI												
1968	1348	1068	1084	1314	1347	1186	1268	1363	1407	1555	1527	1583
1969												
INFIA												
1968	2468	2845	2578	2605	4100	1844	1475	2231	1809	1419	1635	1555
1969												

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ARMY DISPOSITIONS - IN ARMY HOSPITALS

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
TOTAL DISPOSITIONS												
1967	6421	6753	7644	7697	8244	8313	8000	6829	7321	8041	8821	7321
1968	8371	8130	8120	9843	12327	9420	9385	10423	11814	11094	10512	10790
Return-to-duty												
1967	3515	3222	3539	3880	4195	4166	4236	4049	4126	4136	3937	3687
1968	3661	2647	3205	3481	4184	3709	3952	4384	5695	5514	5322	5406
Im-Country-Transfer												
1967	1608	1785	1867	1728	2158	2005	1835	1563	1733	2246	2441	1995
1968	2202	2150	2512	3526	4241	3109	3386	3420	2808	2683	2439	2304
Off-Shore-Evacuations												
1967	1108/ 291	1489/ 175	1894/ 231	1778/ 207	1584/ 204	2017/ 65	1778/ 215	1014/ 133	1288/ 98	1527/ 70	2249/ 103	1833/ 125
1968	2281/ 102	3144/ 82	2244/ 68	2608/ 135	3663/ 137	2365/ 159	1747/ 230	2342/ 200	3055/ 179	2680/ 156	2505/ 173	2840/ 169
Hospital Deaths												
1967	34	49	63	41	60	29	48	31	53	47	66	65
1968	82	104	85	90	129	72	62	72	66	56	70	60
Other Dispositions												
1967	65	33	50	65	43	31	38	30	23	15	25	16
1968	23	1	2	3	9	6	5	5	11	5	3	11

Sources: Beds and Patient Report (DA Form 2789)

1967 DIRECT IDIA ADMISSIONS AND DISPOSITIONS - HOSPITAL

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
IDIA Admissions												
1967	1231	1519	1972	1566	1994	1585	1118	1124	1238	1323	2188	1660
1968	2463	2845	2578	2605	4097	1855	1415	2229	1809	1419	1635	1555
Total IDIA Dispositions From Hospital												
1967	1441	1716	2665	2262	2677	2074	1707	1640	1659	2019	3065	2129
1968	3030	4224	3618	4112	5812	2973	2512	3039	3157	2361	2393	2630
In-Country Evacuation												
1967	560	645	957	827	882	672	443	447	611	908	1154	456
1968	1135	1180	2431	1718	2394	1236	940	1383	959	770	755	811
Evacuation To PACOM												
1967	376	463	911	649	1102	752	546	500	523	529	1102	961
1968	1235	2255	1709	1703	2433	1257	900	1215	1405	993	1018	1124
Evacuation To COMUS												
1967	140	83	104	64	73	65	56	133	15	18	23	35
1968	24	27	8	31	24	11	19	24	30	15	19	19
Hospital Deaths												
1967	28	38	54	32	48	29	32	28	41	32	50	47
1968	71	91	72	77	113	57	43	59	53	40	46	44
Returns-to-Duty												
1967	537	487	639	690	572	556	570	493	469	532	736	630
1968	565	671	638	527	846	412	670	358	718	543	554	632
Other Dispositions												
1967	-	-	2	-	-	1	-	39	-	-	-	-
1968	-	-	-	1	2	-	-	-	-	-	1	-

Source: Beds and Patient Report (IA Form 2789)

AVERAGE DAILY ADMISSION RATE - ALL FACILITIES
(per 1,000 troop strength)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
ALL Camps												
1966	1.12	1.57	1.42	1.55	1.54	1.75	1.40	1.42	1.45	1.45	1.47	1.40
1967	1.27	1.38	1.40	1.45	1.62	1.44	1.43	1.25	1.37	1.52	1.46	1.34
1968	1.33	1.36	1.43	1.58	1.63	1.27	1.30	1.59	1.47	1.33	1.31	1.33
1969												
Dispersed												
1966	.79	.93	.93	1.08	1.07	1.27	1.10	1.04	1.08	1.12	1.08	1.06
1967	.88	.87	.90	1.02	1.11	1.04	1.07	.93	1.01	1.12	.97	.95
1968	.80	.65	.80	.85	.93	.89	.93	1.04	1.03	.97	.90	.94
1969												
IBIA												
1966	.20	.23	.23	.24	.20	.20	.16	.19	.21	.20	.21	.20
1967	.19	.19	.20	.20	.20	.18	.17	.16	.18	.21	.20	.19
1968	.18	.17	.21	.22	.20	.17	.18	.20	.18	.18	.18	.20
1969												
IBIA												
1966	.13	.43	.28	.23	.26	.28	.13	.19	.16	.13	.18	.14
1967	.20	.32	.30	.23	.31	.22	.20	.17	.18	.19	.28	.20
1968	.35	.54	.44	.51	.50	.21	.19	.35	.26	.18	.23	.19
1969												

Morbidity Report (DA Form 8-263). Average Strength, Periodic Personnel Report.

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ARMY DAILY MORTALITY RATE - ALL FACILITIES
(per 1,000 troops)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
All Countries												
1966	9.91	11.61	10.78	11.64	11.89	12.08	12.76	12.35	14.18	13.48	11.89	12.43
1967	10.5	9.77	10.38	10.19	10.99	10.20	10.44	10.28	10.14	10.80	11.20	9.31
1968	9.4	8.15	8.16	9.10	10.80	10.92	9.75	10.24	9.60	9.31	8.87	8.73
1969												

Source: Mortality Report (DA Form 8-268).

HOSPITAL BED STATUS

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Beds Operational												
1966	1896	2031	2053	2499	2708	2820	3020	3280	3462	3549	3656	3828
1967	3148	3163	3328	3506	3608	3808	3948	3880	4090	4141	4235	4245
1968	4305	4350	4265	4525	4905	4905	5065	5365	4787	5287	5597	5357
Average Daily Beds Occupied												
1966	1179	1260	1148	1341	1643	1615	1888	1818	1736	1629	1603	1889
1967	1790	1764	1935	2031	2003	2200	2305	2171	2280	2460	2639	2387
1968	2465	2642	2376	2583	2689	2622	2680	2785	2597	2908	3176	3162
Percent of Beds Occupied												
1966	62.18	62.04	55.92	53.66	62.08	61.74	67.38	63.17	67.30	70.53	67.24	65.56
1967	56.86	55.77	58.14	57.92	55.51	57.78	58.38	55.95	55.75	59.40	62.31	56.20
1968	57.25	56.13	52.66	57.08	54.82	53.47	52.91	51.91	54.25	56.13	56.74	59.02
Average Length of Patient Stay												
1967	7.41	6.48	6.91	6.93	6.57	6.91	7.61	8.26	7.	8.04	7.69	8.22
1968	7.67	6.48	7.34	6.13	5.80	6.60	7.07	6.62	9.44	7.35	7.53	7.54

Source: Beds and Patient Report (DA Form 2789)

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CONFIDENTIAL CENTER BED STATUS

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Beds Operational												
1966	-	-	-	-	160	200	250	450	1000	1000	1000	1000
1967	1000	1000	1000	1000	1200	1200	1200	1200	1300	1300	1300	1300
1968	1300	1300	1300	1300	1300	1300	1300	1300	1300	1300	1300	1300
Average Daily Beds Occupied												
1966	-	-	-	-	35	126	147	254	594	793	721	865
1967	730	598	799	860	1078	1149	1174	1069	895	966	1056	819
1968	645	775	830	1094	1095	1109	1196	1137	1037	912	939	891
Percent of Beds Occupied												
1967	73.00	59.80	79.90	86.00	89.83	95.75	97.8	82.23	68.85	74.31	81.23	63.00
1968	49.62	59.62	63.85	83.15	84.23	91.46	92.00	87.46	79.8	70.2	72.23	68.54
Average Length of Patient Stay												
1967	22.53	27.41	28.57	30.68	32.31	24.35	31.11	21.71	18.76	19.44	17.21	18.24
1968	15.01	18.31	20.10	18.61	14.68	19.18	18.33	17.77	13.44	16.98	18.95	20.02

Source: Beds and Patient Report (DA Form 2769)

MONTHLY RATE
(per 1000 Admissions)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Total-All Facilities												
1966	11.1	10.3	5.4	5.0	7.8	6.6	5.7	4.7	4.9	4.3	5.6	5.1
1967	5.8	7.9	9.0	6.6	8.1	7.4	8.0	6.5	9.3	7.3	9.2	10.6
1968	12.9	18.2	13.1	11.5	14.1	8.3	9.6	11.3	13.5	11.6	16.1	13.9
1969												

Army-All Facilities

1966	7.4	9.0	4.3	3.6	6.4	5.0	4.6	3.9	3.6	2.9	3.5	2.7
1967	3.6	5.0	5.5	3.8	4.6	3.1	3.6	3.1	4.2	3.2	4.8	4.8
1968	6.4	8.6	6.0	5.5	6.4	3.9	3.4	4.6	4.3	4.0	5.5	4.3
1969												

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Total-Hospitals

1966	15.0	15.4	7.5	7.8	9.3	11.9	7.9	6.8	6.9	6.0	9.7	7.2
1967	8.9	12.8	15.0	10.6	14.2	12.4	14.2	11.3	15.8	13.1	15.7	18.0
1968	21.3	29.6	23.9	21.6	20.9	13.4	19.2	17.8	22.0	17.5	31.7	23.7
1969												

Army-Hospitals

1966	10.0	13.5	6.4	5.8	8.0	8.5	6.7	6.1	5.1	5.2	6.5	5.2
1967	6.3	8.4	9.7	6.2	8.5	5.7	7.0	5.5	8.2	6.7	9.0	9.9
1968	11.9	16.5	12.7	12.6	13.1	6.5	5.6	8.4	8.1	6.9	9.0	7.6
1969												

Source: Beds and Patient Report (DA Form 2789) and Morbidity Report (DA Form 8-268)

INDIVIDUAL MEDICAL RECORDS PROCESSED

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Individual Medical Records Received												
1966	5636	7271	8328	13487	11168	11289	12918	12667	10542	14886	13380	18408
1967	17214	13335	15803	16048	17614	16139	17533	16852	17135	19414	20817	18411
1968	20845	19496	18738	19434	21878	19871	19392	21413	18900	17502	16951	18361

1969

Forwarded to DA

1966	5247	4638	7070	7257	10128	10342	9261	10080	8818	13228	12291	16193
1967	16543	12863	15264	15218	17164	15702	16847	16423	16493	19200	20313	17722
1968	20423	19168	18442	18509	21401	19447	18721	19818	17828	17161	15973	17425

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Returned to Units for Correction

1966	205	1306	867	3243	681	865	504	417	631	1606	897	169
1967	169	492	539	830	450	437	686	429	442	214	598	689
1968	422	328	276	525	477	424	677	952	1072	341	978	936

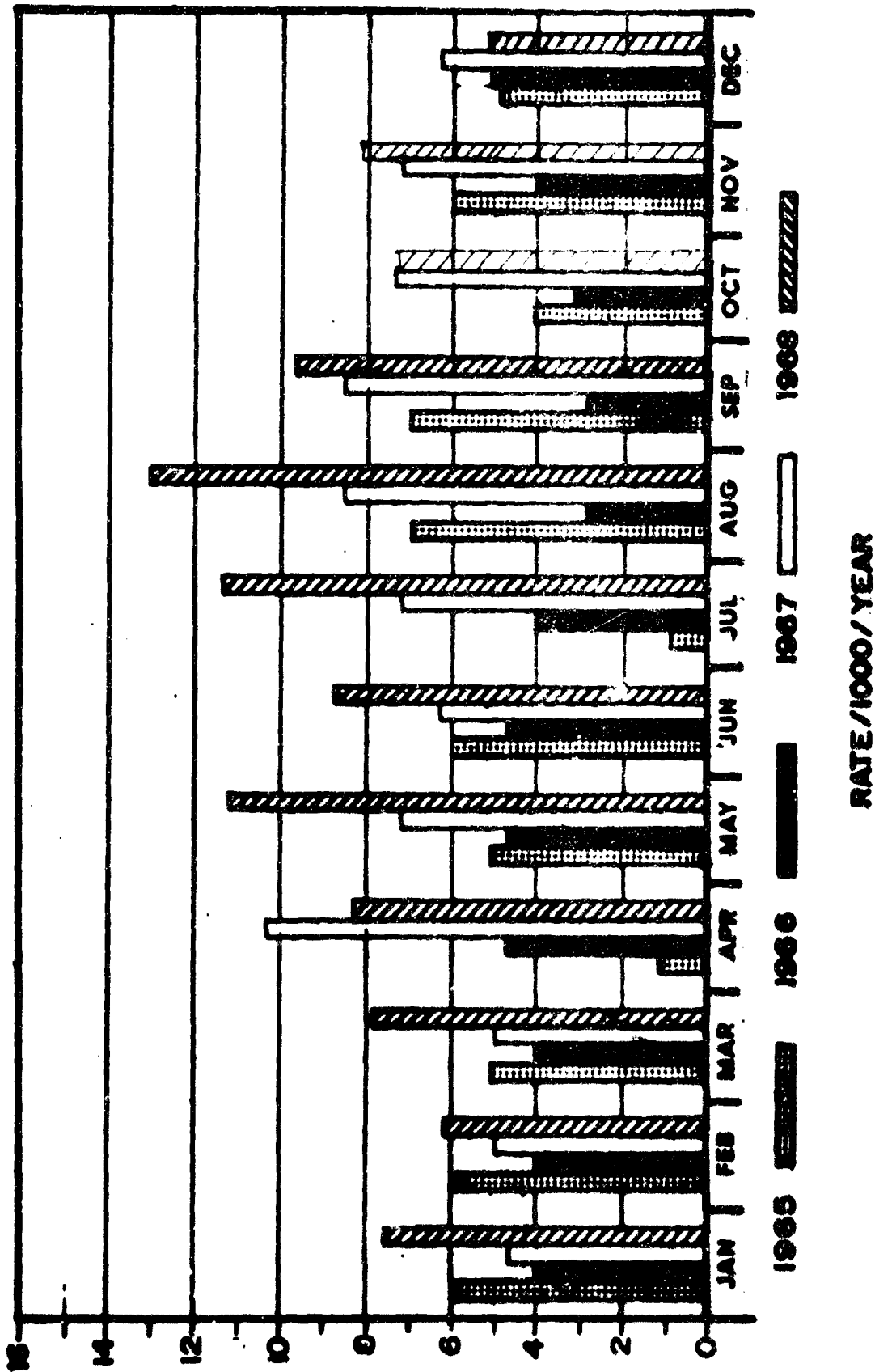
1969

Corrected or Late Records from Previous Periods Transmitted to DA

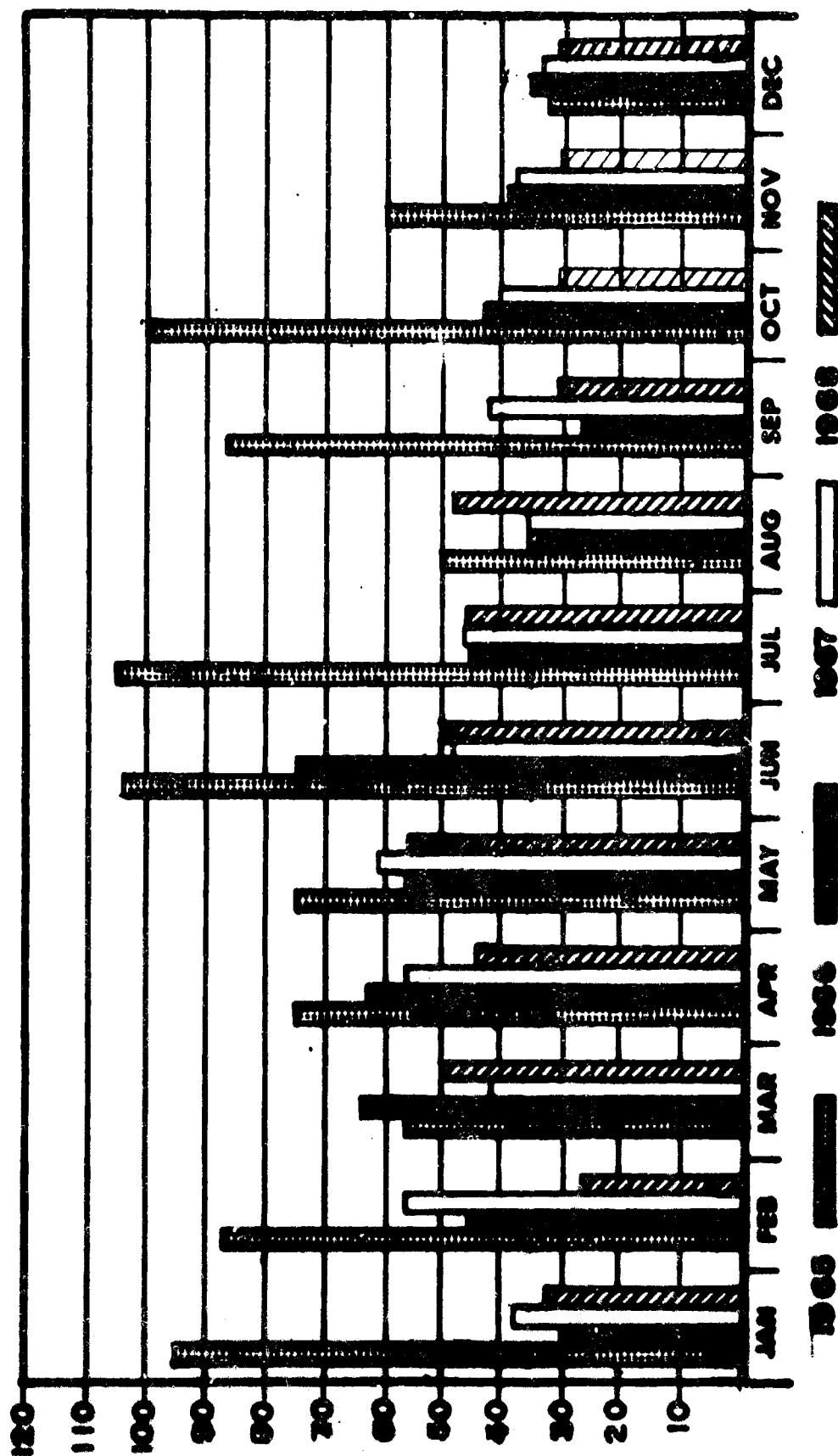
1966	154	1302	391	2587	359	82	2153	2170	1093	1074	144	2846
1967	2046	770	286	1273	900	1629	1195	1216	895	831	1512	972
1968	2449	2707	1431	629	544	1937	863	643	1634	2821	2839	798

1969

HEPATITIS



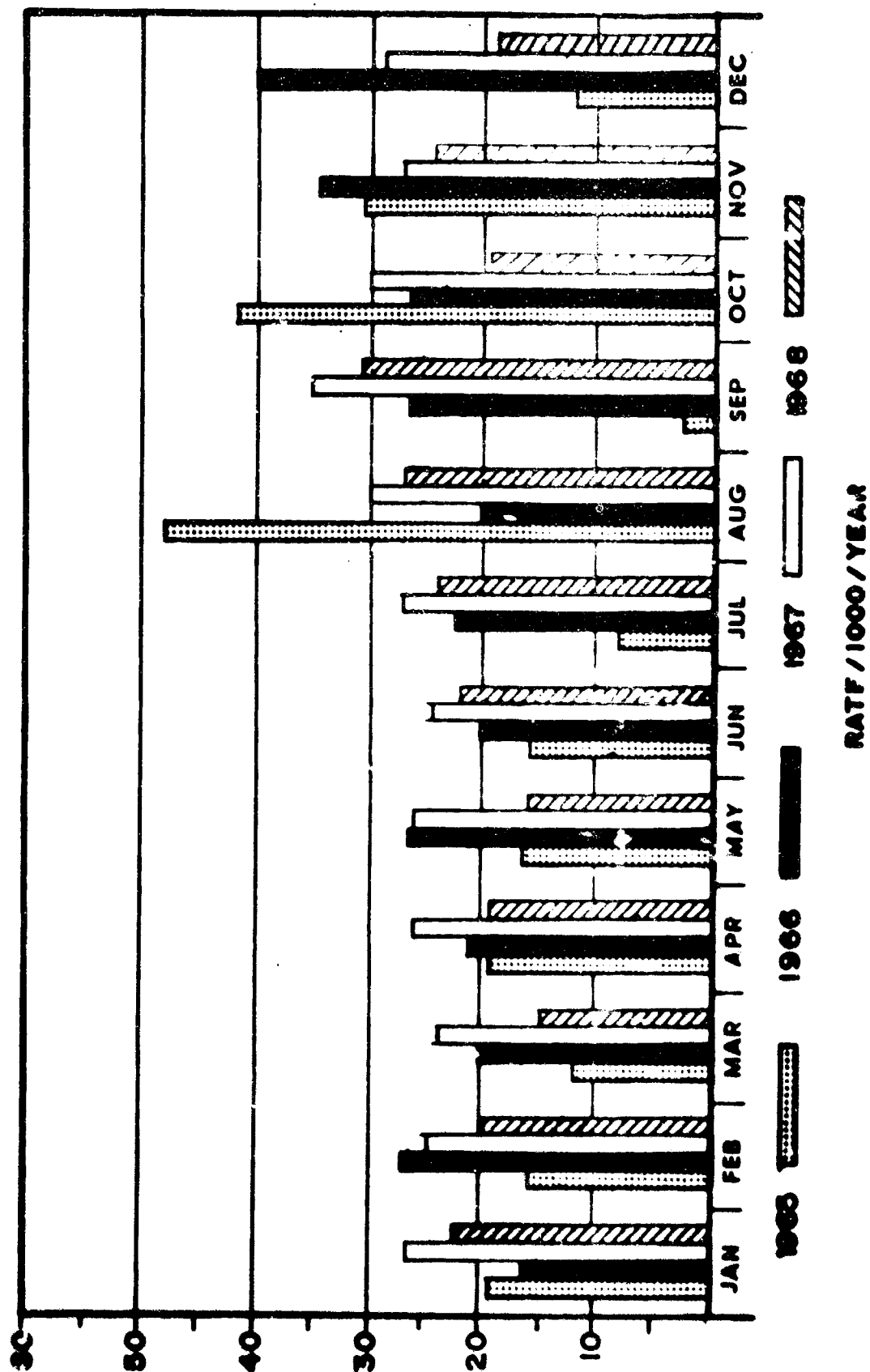
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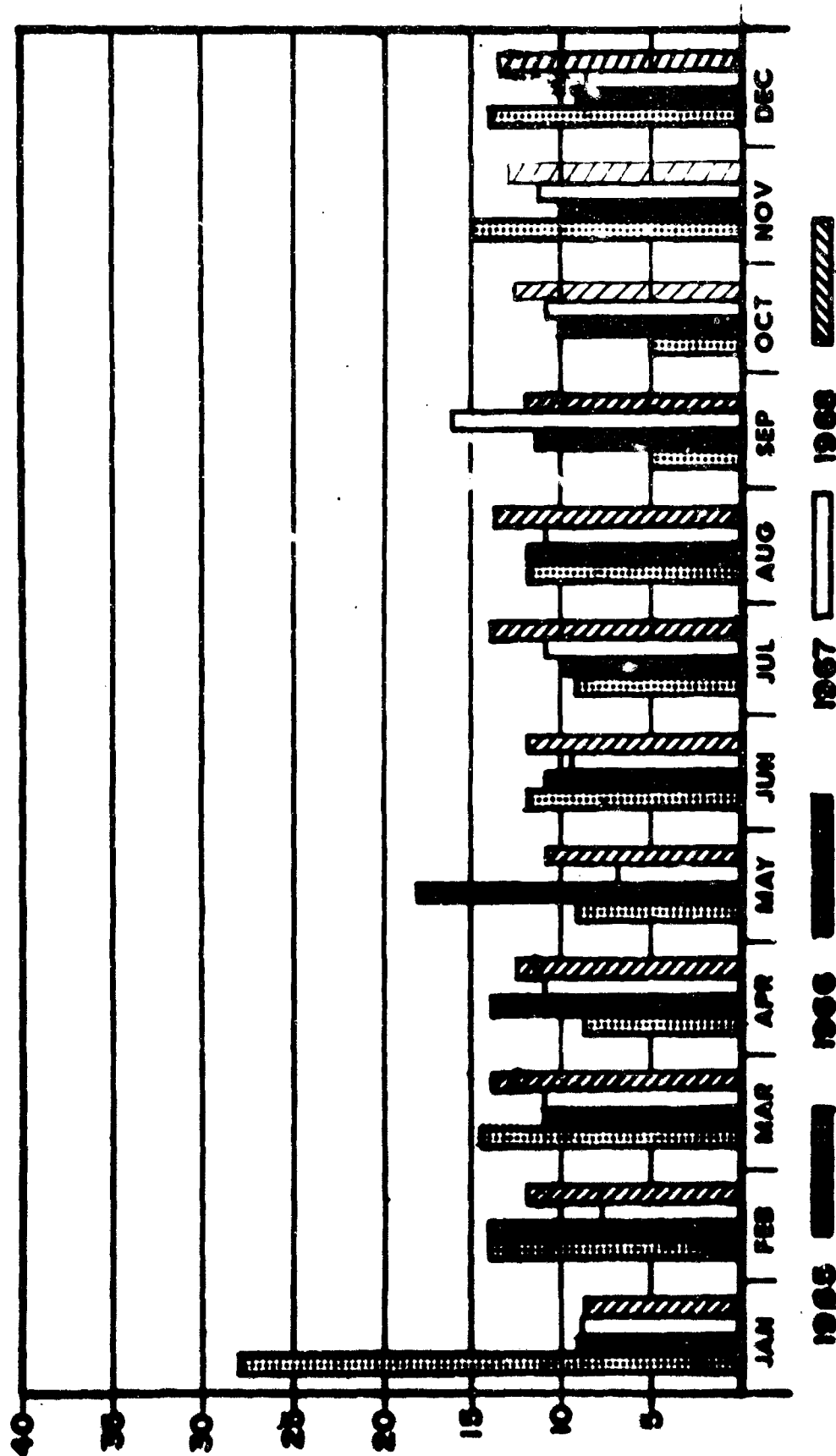
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SKIN DISEASES



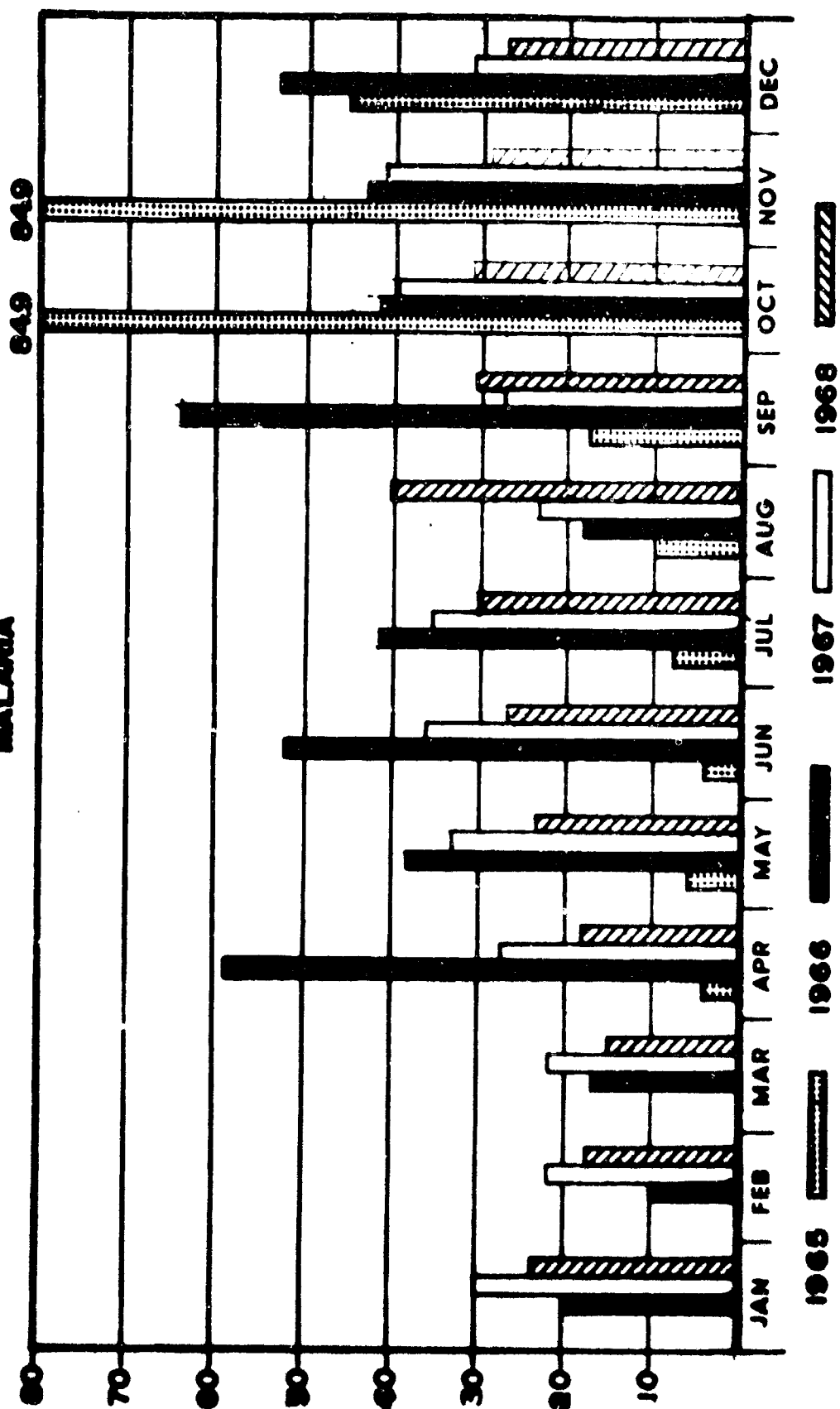
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RATE / 1000 / YEAR

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(81)

MALARIA



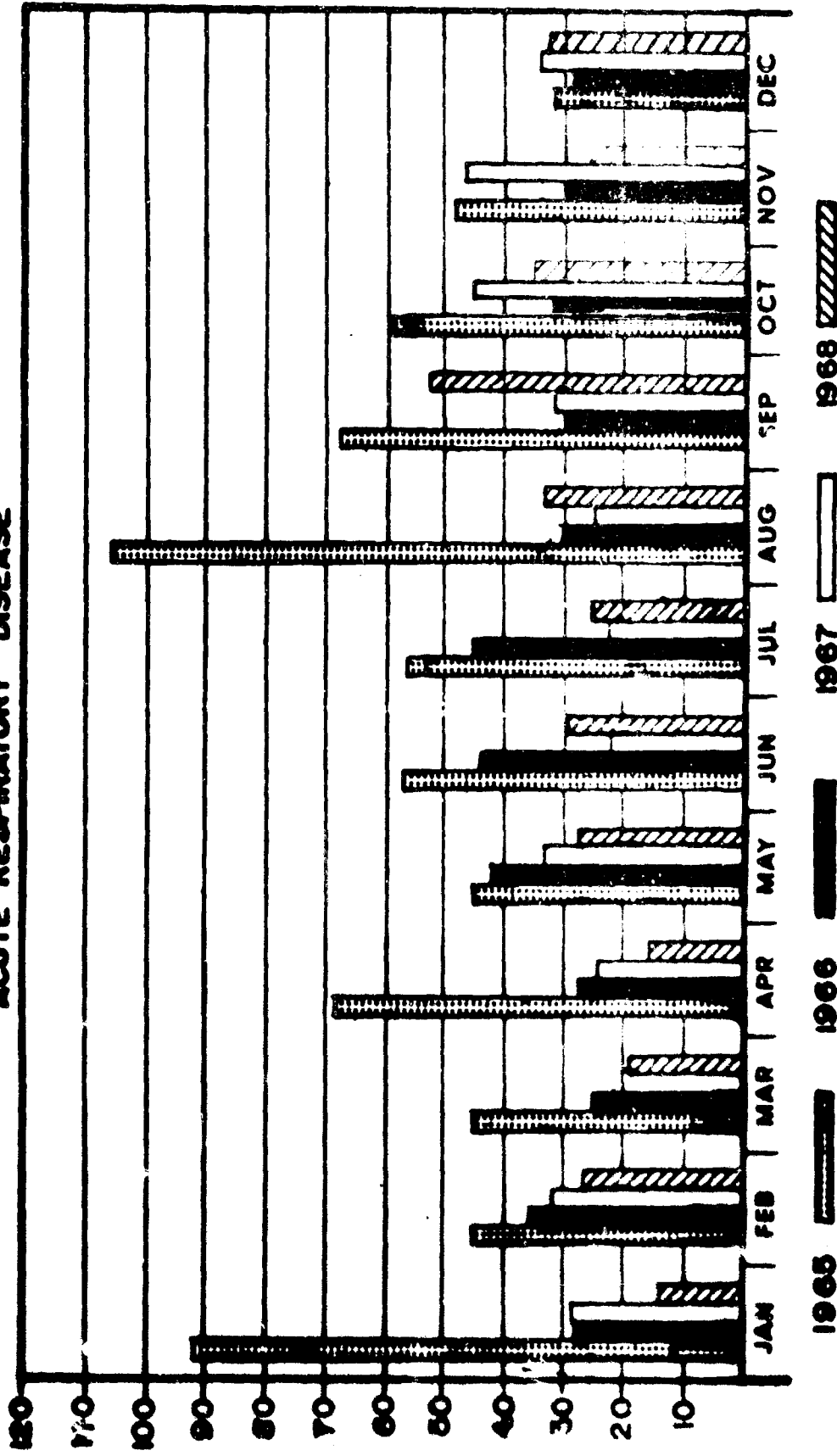
RATE/1000/ YEAR

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RATE / 1000 / YEAR

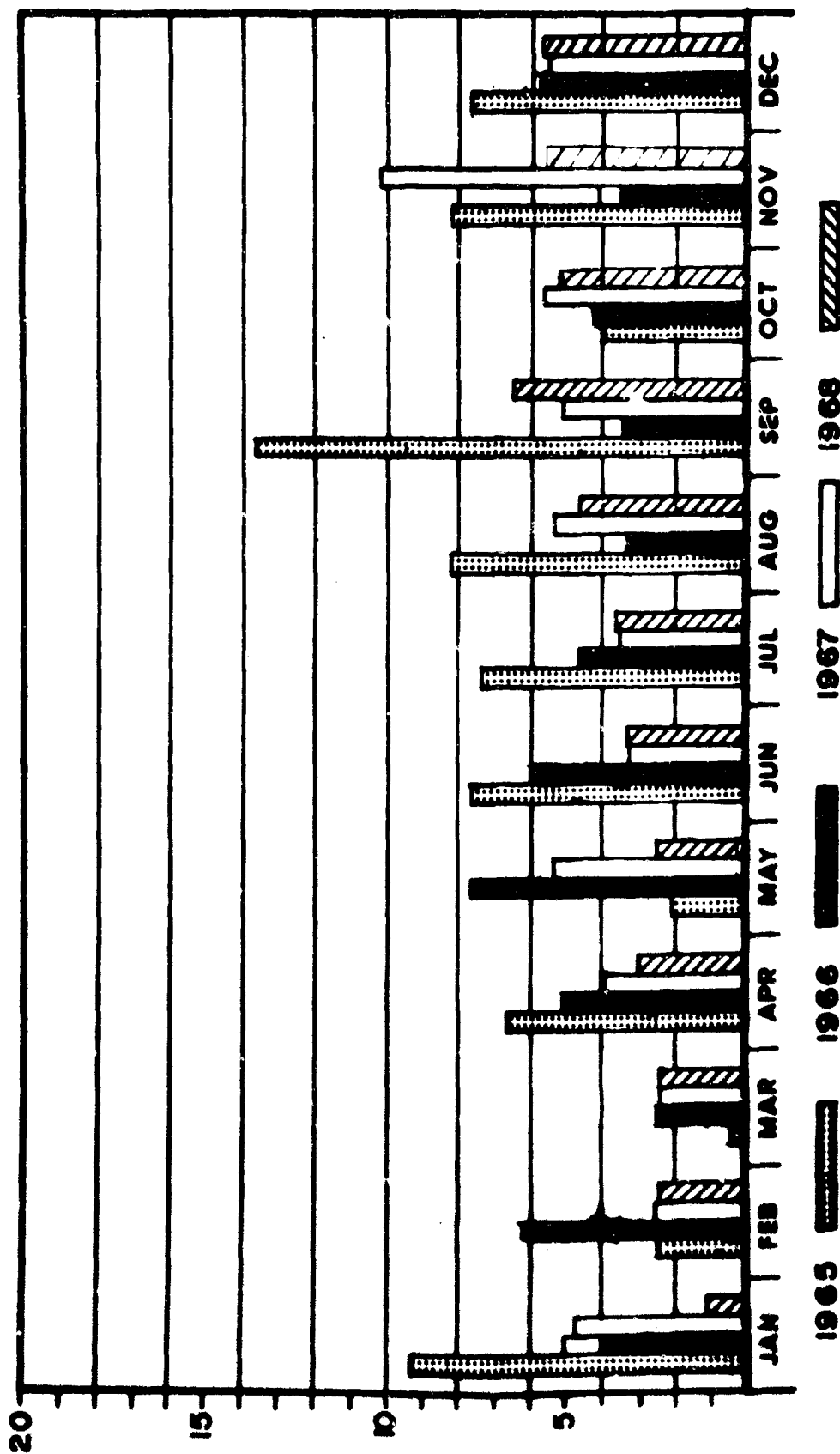
ACUTE RESPIRATORY DISEASE



RATE / 1000 / YEAR

(27)

PNEUMONIA



RATE/1000/YEAR

(85)

UNCLASSIFIED

SECRET

Security Classification

DOCUMENT CONTROL DATA - R & D

(Security classification of title, body of abstract and indexing annotation must be entered when the overall report is classified)

1. ORIGINATING ACTIVITY (Corporate author) HQ DA, OACSFOR, Washington, D.C. 20310		2a. REPORT SECURITY CLASSIFICATION SECRET	
		2b. GROUP 4	
3. REPORT TITLE Senior Officer Debriefing Report: BG Spurgeon Neel			
4. DESCRIPTIVE NOTES (Type of report and inclusive dates) Sr. Officer Debriefing Report of CG, 44th Med Bde & Surgeon of HQ USARV, Aug 68 - Feb 69.			
5. AUTHOR(S) (First name, middle initial, last name) BG Spurgeon Neel			
6. REPORT DATE 1 February 1969		7a. TOTAL NO. OF PAGES 88	7b. NO. OF REFS
8a. CONTRACT OR GRANT NO.		8b. ORIGINATOR'S REPORT NUMBER(S) 69B009	
b. PROJECT NO N/A		8c. OTHER REPORT NO(S) (Any other numbers that may be assigned this report)	
10. DISTRIBUTION STATEMENT			
11. SUPPLEMENTARY NOTES N/A		12. SPONSORING MILITARY ACTIVITY DA, OACSFOR, Washington, D.C. 20310	
13. ABSTRACT			

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SECRET

DD FORM 1473

UNCLASSIFIED
Security Classification